# STATE TITLE V BLOCK GRANT NARRATIVE
# STATE: IL
# APPLICATION YEAR: 2006

# I. GENERAL REQUIREMENTS

## A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

## B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

## C. ASSURANCES AND CERTIFICATIONS

The Department's assurances and certifications of compliance with federal statutes and regulations that pertain to the Maternal and Child Health Block Grant are on file at the Office of Family Health's headquarters in Springfield. Copies may be obtained by writing or calling the office:

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## D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

## E. PUBLIC INPUT

The MCH Block Grant application was made available for public review and comment between the dates of June 17 and July 1, 2005. On June 21, 2005 a draft was distributed to chairpersons of the following advisory committees or a senior member of the following organizations: the Illinois Maternal and Child Health Coalition; the Family Planning Advisory Council; the Perinatal Advisory Committee; the Genetic and Metabolic Diseases Advisory Committee; the Genetics Task Force of Illinois; Voices for Illinois Children; the Maternal and Child Health Training Program at the University of Illinois at Chicago School of Public Health; the Illinois Association of Public Health Administrators; the Illinois Public Health Nursing Administrators Association; Family Voices of Illinois; the Newborn Hearing Screening Advisory Committee; and DSCC's Family Advisory Council. It was posted on the Internet at www.dhs.state.il.us between June 17, 2005 and July 1, 2005. A legal notice inviting public comment was published in the Edwardsville Intelligencer, the newspaper currently designated for publication of the State's legal notices, on June 22, 26, and 28, 2005. Comments were received from several invited reviewers.

## II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

## III. STATE OVERVIEW

### A. OVERVIEW

Population. Illinois ranks fifth in the nation in population, with 12.6 million people, including 3.5 million children under the age of 18, according to Census Bureau's population estimates as of July 1, 2003. In the year 2003, there were approximately 2.7 million women in Illinois who were of childbearing age (15 to 44 years). In recent years, Illinois has averaged about 183,000 live births annually. An average of 45,400 pregnancies are aborted each year.

According to the 2002 National Survey of Children with Special Health Care Needs (CSHCN), there are about 379,436 CSHCN in Illinois, or 11.6 percent of children under 18 years of age. The survey identified 323,385 Illinois households with CSHCN or 19.2 percent of the state's households. In comparison, the survey identified 9.4 million CSHCN nationally, or 12.8 percent of children under 18 years of age. Nationally, 20 percent of all households had a CSHCN. DSCC serves approximately 23,000 CSHCN with their current resources.

Sixty-six percent of the state's population resides in Chicago and the six "collar" counties that surround it in the northeast corner of the state, and two counties (Cook and DuPage) account for half of the state's population. Excluding Chicago, 25 cities of 50,000 or more in population account for about 2.0 million persons, or about 16 percent of the state's population. As of the 2000 Census, there were 12 counties outside the collar counties whose populations exceeded 100,000. Other than these population centers, Illinois is characterized by rural areas. Using a standard of fewer than 60,000 residents to define "rural," 84 of the 102 counties are considered rural. About two-thirds of Illinois' population (Chicago and the collar counties) is concentrated on less than ten percent of its land, while the majority of the state is characterized by small towns and farming areas.

In 2003, the U.S. Census Bureau estimates that 79.5 percent of the state's population are Caucasian, 15.2 percent are African-American, 4.1 percent are Asian, Native Hawaiian or Other Pacific Islander, 0.3 percent are Native American, and 1.0 percent are multiracial; 13.6 percent of the state's population is of Hispanic origin. Chicago is home to more than half of the state's African-Americans and 49 percent of the state's Hispanic-Americans.

The size of Illinois' rural area is a significant geographic barrier to health care. The Illinois Department of Public Health's (IDPH) Center for Rural Health reports that there are 84 rural counties and 18 urban counties in Illinois. The Center further reports designation of Health Professional Shortage Areas. (HPSA's) by county, township and Census tract. All but ten counties (92 percent of Illinois) have some category of HPSA designation: 23 are geographic; 54 are low-income population; and 15 are sub county level. This problem of provider distribution in rural areas creates barriers to care arising from problems with transportation, child care, hours of service, and related concerns.

Summary of Health Status. The most important health care needs of the state's population can be considered by population group:

Maternal and Infant Health
Early and continuous access to prenatal care remains a challenge. Overall, 82 percent of the pregnant women in Illinois initiate prenatal care in the first trimester, while 78 percent receive adequate care (using the Kotelchuck Index of adequate prenatal care) throughout pregnancy.

Illinois' infant mortality rate has declined steadily for the past decade, and has declined 25 percent since 1993. The rate of 7.2 per 1,000 for 2002 is an all-time low for the state of Illinois. After holding steady at 8.2 per 1,000 (1997 and 1998) and 8.3 per 1,000 the following two years, the infant mortality rate for Illinois decreased by 13 percent between 2000 and 2002. The state's 2002 rate (7.2 per 1,000) still compares unfavorably with the provisional rate for the nation as a whole (7.0 per 1,000). Significant racial disparities in infant mortality persist by racial and ethnic groups: the rate for African-Americans is more than twice that of Caucasians (2.9:1 in 2002). The 2002 rate for African-American babies rose to 15.7 per 1,000 live births in 2002 from 14.9 in 2001. The Caucasian rate dropped from

5.9 per 1,000 live births in 2001 to 5.5 per 1,000 live births in 2002. The 2001 rate for African-American babies eclipses the previous low of 16.3; the Caucasian rate of 5.5 also dropped below the previous low of 5.9 recorded in 2001. Chicago's infant mortality rate in 2002 was 8.6 per 1,000 live births, surpassing the previous low of 9.0 per 1,000 live births in 2001. The downstate infant mortality rate (all geographic areas outside the city of Chicago) was 6.7 per 1,000 live births in 2002, down from 6.9 per 1,000 live births in 2001. The downstate infant mortality rate for 2002 is a new low.

A total of 180,555 infants were born to Illinois residents in 2002, and 1,304 infants did not live to their first birthday that year.

Childhood Health
According to CDC's National Immunization Survey data, the proportion of children in Illinois who are fully immunized reached 84.3 percent by June 2004.

During FFY 2003 (the most recent data available), more Medicaid-eligible children received well child screenings than in previous years, based on the Center for Medicare and Medicaid Services (CMS) definitions. The overall participation ratio rate was 73.1 percent of eligible children receiving at least one screening in FFY'03. The total number of eligible children in FFY'03 was 1,146,996. The participation rate is highest among infants (93.8 percent). The rate is lower among one to two-year-olds (73.3 percent), three to five-year-olds (63.2 percent), and six to nine-year-olds (56.1 percent). The participation rate is highest among ten to fourteen-year-olds (97.8 percent). For fifteen to eighteen-year-olds, the rate is 64.8 percent. The participation rate for nineteen and twenty-year-olds was 79.8 percent in FFY'03. Of the seven states with Medicaid, enrollment of more than one million eligible children, Illinois ranked second in participation for FFY'03.

Adolescent Health
The number of teen births has declined by 19 percent in the last five years, and the proportion of infants born to teenage mothers has declined by 19 percent at the same time. There were 17,670 births to teenagers in 2003; this represented 9.7 percent of all live births in the state. More than 85 percent of these young mothers were unmarried at the time they gave birth, posing a significant challenge for obtaining and maintaining economic self-sufficiency.

While the number of teen births decreased among Caucasian and African-American teens between 1999 and 2003, the number of births in that time period to Hispanic teen mothers peaked at 6,004 in 2001 and then dropped to 5,437 in 2003. While the number of Hispanic teen births in the city of Chicago decreased by 241 births between 1999 and 2003, the number downstate increased by 197 births. Most of these births occurred in the metropolitan counties surrounding the city of Chicago

Reproductive Health
Illinois has about 706,500 women of reproductive age in need of subsidized family planning services. Illinois' Family Planning program had enough resources to serve only 21 percent of the women in need during CY'04.

Children with Specail Health Care Needs
Through increasing awareness efforts, the Medical Home concept has now become a part of several grant activities in Illinois that involve quality improvement processes in physician practices, improving access to a Medical Home in the Head Start Association and Epilepsy Foundation, a Care Coordination Organizer funded through the American Legion, and a web-based information source for families and physicians about chronic health conditions managed in the primary care setting. Increased awareness of the Medical Home concept was accomplished through presentations at hospital grand rounds, in-office educational programs, new articles, various family programs, and word of mouth.
The Illinois Interagency Coordinating council on Transition has focused efforts on cross-agency training for member agencies on transition planning and services to improve access to transition services for youth with disabilities and their families.
IDHS, IDPH, and DSCC have focused efforts on improving screening, evaluations, interventions, and

reporting for newborns through the Newborn Hearing Screening Program.

SFY'06 Budget Update.
Young children's education and working families' health care are strengthened significantly by the budget that Illinois legislators have approved and sent to the Governor
for consideration. Among other important priorities, the budget for the fiscal year beginning July includes:

$30 million more for the Early Childhood Block Grant, further expanding pre-K for at-risk three and four-year-olds as well as developmental services for younger, at-risk children. This fulfills Governor Blagojevich's pledge to increase preschool funding by $90 million over three years.
More than $300 million in total new funding for elementary and secondary education, which includes raising schools' "foundation level" by $200 per pupil, as well as increasing resources for after-school, bilingual, anti-truancy and alternative-education efforts.
$5.75 million to complete implementation of the Family Care program, offering health care to more than 50,000 more low-income working parents. This, too, fulfills a gubernatorial pledge to help families who couldn't otherwise obtain insurance.
Protection of the Healthy Families Illinois Parents Too Soon home visiting programs and Crisis Nurseries from previously proposed cuts, as well as restoration of about $20 million in funding that was temporarily cut from state-supported child care for low-income, working families.

Health Care Financing. Enrollment in Health Maintenance Organizations (HMOs) continues to decline. In 2003 (the most recent data available), 18.5 percent of the state's population was covered by an HMO. There were 26 licensed HMOs in the state in 2003, 12 less than in 2001. The ten largest HMOs covered 1.7 million persons in 2001, a 35 percent decrease from the 1999 peak of 2.6 million. Four of the ten largest plans have enrollments in excess of 100,000 persons: Health Care Service Corporation, Humana Health Plan, Unicare Health Plans, and Health Alliance Medical Plans. These four HMOs have enrolled about 1.4 million persons, or 78 percent of the total.

Changes in hospital ownership have not affected affiliation agreements for the regionalized perinatal care system. The number of hospitals providing obstetrical care has been declining; currently 138 hospitals are licensed to provide this service.

Five Managed Care Organizations (MCOs) participate in the voluntary managed care program for certain Title XIX and Title XXI participants in Cook County. One of those MCOs also serves certain Title XIX and Title XXI participants in St. Clair, Madison, Franklin, Jackson, Perry, Randolph, Washington, and Williamson Counties. As of March 2005, these managed care programs served 174,855 people, an increase of more than 18,000 people since May 2004.

Children in low-income families may have health insurance either through the Medicaid program or through the State Child Health Insurance Program (SCHIP). The programs are operated in Illinois by the Illinois Department of Healthcare and Family Services (IDHFS), formerly the Illinois Department of Public Aid under the name "KidCare." Currently, approximately 1.2 million children (one-third of all children in the state) are eligible for Medicaid at some time during the year. The U.S. Census Bureau estimates that 231,000 uninsured children are potentially eligible for KidCare. IDHS, IDPH (through the Dental Sealant Program) and the University of Illinois' Division of Specialized Care for Children are working closely with the DHFS to increase the number of children who have health benefits coverage through the Title XIX (Medicaid) and Title XXI (State Child Health Insurance or SCHIP) programs.

KidCare, Illinois' health insurance program for children, has five components:

•KidCare Moms and Babies - coverage through Title XIX for pregnant women and their infants up to age one year with income up to 200 percent of the FPL.
•KidCare Assist - coverage through Title XIX for children through age 18 with family income at or below 133 percent of the FPL.

•KidCare Share - coverage through Title XXI for uninsured children through age 18 with family income above 133 percent and at or below 150 percent of the FPL. Co-payments of $2 per prescription and $2 per medical visit are required, except for well-child visits and immunizations.
•KidCare Premium - offers coverage through Title XXI for uninsured children through age 18 with family income above 150 percent and at or below 200 percent of the FPL. Monthly premiums of $15 for one child, $25 for two children or $30 for three or more children are required. Co-payments of $5 per medical visit, $5 for brand name prescriptions and $3 for generic prescriptions as well as an optional $25 co-payment for non-emergency use of hospital emergency room services. There are no co-payments for well child visits or immunizations. Co-payments under both plans ("Share" and "Premium") are capped at $100 per family per year.
•KidCare Rebate - uses Title XIX and Title XXI funds provided through a HIFA waiver to provide a payment to families with private health insurance coverage for their children. It allows a maximum reimbursement up to $75 per eligible child per month for the premium costs paid by the family to purchase private health insurance that provides, at a minimum, physician's services and hospitalization. Children through age 18 with family income above 133 percent, and at or below 200 percent of the FPL are eligible.

Illinois also provides presumptive eligibility for children under both Title XIX and Title XXI.

Illinois has obtained a waiver under Title XXI to operate FamilyCare. FamilyCare provides health insurance coverage to parents with income equal to or less than 185 percent of the FPL. Governor Blagojevich requested funds to increase the eligibility threshold for FamilyCare to 133 percent of the federal poverty level in SFY'05 and from 133 to 185 percent of the federal poverty level for SFY'06.

Currently, no premiums are required under FamilyCare. Co-payments of $2 per medical visit and $3 for brand name prescriptions are required.

In 2004, the Illinois DHFS submitted a report to the Governor and General Assembly on optional services for pregnant women that could be implemented under the Medicaid program. The top priorities identified in the report were:

Expansion of FamilyCare eligibility;
Expansion of family planning services for women who are leaving public assistance;
Expansion of Targeted, Intensive Prenatal Case Management through the addition of new program sites;
Coverage of treatment for dental caries and periodontitis in pregnant women;
Development of a smoking cessation program for pregnant women;
Development of new outreach strategies to engage pregnant women who are "hard to reach;" and
Creation of a statewide perinatal mental health consultation service for the treatment of peripartum depression.

Several priorities have been or are being addressed:

FamilyCare eligibility was expanded;
IDHFS's long-standing request for a waiver to extend Medicaid coverage of family planning services was approved and was implemented in April 2004 as the Illinois Healthy Women Initiative;
Two Targeted Intensive Prenatal Case Management program sites were added during SFY'05 and more will be added in SFY'06;
IDHFS adopted policy to allow reimbursement for perinatal depression screening which was effective in December 2004. The Perinatal Mental Health Consultation Service was also implemented in December 2004, with financial support from MCHB. In addition, the IDHS developed materials for the web site, including a brochure, links to other information, hotline numbers, support groups, outpatient clinics, and inpatient services.
IDHS is working in collaboration with the IDPH and IDHFS to promote the IDPH Tobacco Quitline. In February 2005, IDHS, IDHFS, and IDPH sent a joint memorandum to all WIC and Family Case Management program grantees encouraging referrals to the Quitline and identifying smoking

cessation services covered by IDHFS. IDHFS will be sending a client information and provider notice about covered smoking cessation products and the availability of the Quit Line.

The following priorities are currently being addressed:
IDHFS conducted extensive research on content of preconception visits, developed a recommendation, and received approval from a panel of experts. Policy is currently being developed to provide reimbursement for an annual preconception visit.
IDHFS received a grant from the Michael Reese Health Trust to fund three projects: (1) Evaluation of a medical record review to assess quality of care in "Closing the Gap" communities and recommend areas for continuing medical education; (2) Implement a pilot to test the efficacy of periodontal care for pregnant women in reducing low birth weight; and (3) Implement a pilot to test the efficacy of fluoride varnish for children 0-3 years of age in preventing caries.

The Illinois Healthy Women (IHW) program is a five-year federal demonstration waiver to provide basic women's health care services, including family planning to eligible women when they lose coverage under one of the IDHFS's medical programs. It began its implementation phase in April 2004. Women who are eligible for participation in the program are systematically selected as they lose Medicaid coverage. Eligible women receive a mailing about the program that includes a three-month enrollment, program description, and enrollment form. There is no application process. In order to be eligible for more than three months, the enrollment form must be returned, thus generating a twelve-month enrollment. Those individuals not eligible for IHW are referred to IDHS' Title X (Family Planning) program for assistance in locating low-cost family planning services in their area.

On February 19, 2004, the DHFS submitted an amendment to the Centers for Medicare and Medicaid Services (CMMS), requesting federal financial match for multivitamins and folic acid and coverage of eligible women in the waiver who are leaving the SCHIP program. Currently, formal response from CMMS is pending. On July 13, 2005, IDHFS submitted a second amendment to request expansion of coverage to include additional women through an application process, regardless if they were previously enrolled in IFS' program. If approved, this approach would serve women whom, if pregnant, would qualify for coverage under the KidCare Moms and Babies program. An expansion of IHW would serve more women, allowing the IDHS Family Planning program to use its resources for those individuals who do not qualify for IHW, i.e., undocumented residents, men, and women younger than 19 or older than 44. It is anticipated that approximately 50,000 additional women will be covered under this expansion, when approved by CMS.

Settlement of Memisovski, et al., v. Maram, et al. The IDHFS and IDHS have signed a proposed consent decree with the plaintiffs to settle the "Memisovski" lawsuit. The suit is a class action brought on March 23, 1992 on behalf of the Class of children in Cook County, Illinois, who, on or after July 1, 1990, have been, are, or will be eligible for the Medicaid program. The lawsuit alleged that IDHFS and IDHS violated the rights of the children in the Class by failing to provide these children with access to medical care and services to an extent at least equal to that available to the general population in the geographic area and by failing to provide them with adequate early and periodic screening, diagnosis and treatment services. On June 24, 2005, after trial in which the Class members prevailed, the parties signed a proposed Consent Decree to resolve the lawsuit.

The courts are currently soliciting public comment on the terms of the Consent Decree. If the terms are approved, the payment for initial evaluation of a pediatric patient will increase between $49 and $62. All of these increases are more than double the current reimbursement. Similarly, the rates for oral health care will increase by $11 to $15. Most notably, the rate per tooth for application of dental sealants will increase to $36, more than two-and-a-half times the current rate. These rate increases will go into effect on January 1, 2006 if the Consent Decree is approved.

Service Delivery System. With the exception of the Teen Parent Services program in part of Chicago, all of the primary and preventive care services in Illinois' Title V program are provided by IDHS or IDPH grantees. Most often, these are local health departments. Community Health Centers also play an integral role in the delivery of primary and preventive care to pregnant women, mothers, infants,

children, and adolescents.

Local health departments were first established in Illinois by "AN ACT to authorize the organization of public health districts and for the establishment and maintenance of a health department for the same" (70 ILCS 905/1, effective July 1, 1917). Municipal health departments are governed by Section 17 of the Illinois Municipal Code of 1961 (65 ILCS 5/11-17-1). The statutory base for county and multiple county health departments (55 ILCS 5/5-25001) was revised July 1, 1990. Local health departments in Illinois are all tax supported to some degree. For county health departments, a local tax levy of as much as 0.1 percent of the assessed value of all taxable property in the county can be instituted through referendum; the actual rate is set, up to the legal maximum, through a vote of the county board (55 ILCS 5/5-25003 and 55 ILCS 5/5-25004). As of July 1, 2004, there were 47 "resolution" health departments (those established by resolution of a county board) and 48 "referendum" health departments. These health departments serve 99.6 percent of Illinois' population.

Community Health Centers. The Illinois Primary Health Care Association reports there are 155 Community Health Centers, Federally Qualified Health Centers or Healthy Schools Health Communities grantees. Many of these centers are maternal and child health grantee agencies providing primary medical care, dental care services, mental health/substance abuse services, obstetrical and gynecological care, or other professional services.

Individual FQHCs receive grants for many MCH programs. The most significant collaboration is in the Chicago Healthy Start Initiative. The Winfield Moody Health Center, the Erie Family health Center and Henry Booth House are the medical partners for three of the four Healthy Start Family Centers. Erie Family Health Center, Lawndale Christian Health Center, and the Chicago Department of Public Health implement the Targeted Intensive Prenatal Case Management project in the city of Chicago. The Southern Illinois Healthcare Foundation is a lead agency for HealthWorks of Illinois. The Department is working with Access Community Health Network and with the Chicago Department of Public Health on the new "Closing the Gap" initiative.

State-Level Initiatives. Three special initiatives at the state level will affect the service delivery system. The Early Learning Council was created in 2003 by Public Act 93-0380 to "coordinate existing programs and services for children from birth to five years of age in order to better meet the early learning needs of children and their families. The goal of the council is to fulfill the vision of a statewide, high-quality, accessible and comprehensive early learning system to benefit all young children whose parents choose it." The council's initial charge is to:

Implement recommendations of previous and ongoing early childhood efforts and initiatives and oversee implementation;
Develop multi year plans to expand programs and services to address gaps and insufficient capacity and enhance quality;
Reduce or eliminate policy, regulatory and funding barriers;
Engage in collaborative planning, coordination and linkages across programs, divisions and agencies at the state level; and
Report to the Governor and General Assembly on the Council's progress toward its goals and objectives on an annual basis.

The council has an Executive Committee and five subcommittees. The MCH Program is represented on four of the five subcommittees.

The Illinois Children's Mental Health Partnership was created by the Illinois Children's Mental Health Act of 2003 to develop and monitor the implementation of an Illinois Children's Mental Health Plan that outlines a comprehensive, coordinated approach to prevention, early intervention and treatment for children ages 0-18 years. The Partnership reports to the Governor and is comprised of representatives from various state agencies and 25 members appointed by the Governor. Appointed members include families, children and family advocacy groups, primary and mental health provider

associations, educators, violence prevention and other groups. Its final implementation plan was submitted to the Governor on June 30, 2005.

There is a growing medical malpractice insurance crisis in Illinois. In response, the Illinois' General Assembly passed Senate Bill 0475, which limits awards for non-economic damages to $500,000 against a physician and $1 million against a hospital. The Illinois Department of Insurance will be required under certain circumstances to hold hearings regarding increases in medical malpractice insurance premiums. The bill is awaiting the Governor's signature.

Allocation of Resources. The IDHS allocates its resources by "Giving highest priority to those areas in Illinois having high concentrations of low-income families, medically underserved areas, and those areas with high infant mortality and teenage pregnancies . . ." (77 Ill. Adm. Code 630.20 (a)(2)). Allocation decisions are made on the basis of competitive proposals, per capita allocations, or by other means. By federal law, IDHS allocates 30 percent to DSCC for CSHCN.

The distribution of resources in the state roughly parallels the distribution of live births. Table 2 (attached) presents the proportion of live births and the proportion of program resources allocated to groups of counties, ranked by the number of live births. For example, Group 1 includes the ten counties with the greatest number of live births (Cook, DuPage, Kane, Lake, Madison, McHenry, Peoria, St. Clair, Will and Winnebago). These counties account for 77 percent of the state's live births and receive 82 percent of the MCH program's grant funds. Group 10, the 12 counties with the least number of live births (Brown, Calhoun, Edwards, Gallatin, Hamilton, Hardin, Henderson, Pope, Putnam, Schuyler, Scott and Stark) account for less than one percent of the state's live births and receive less than one percent of the MCH program's grant funds. Cook County has 45 percent of the state's live births and receives 69 percent of the grant funds from the Office of Family Health. This apparent imbalance is the result of analyzing the distribution of program resources by the location of the contractor. Several large program contractors in Chicago subsequently distribute resources to subcontractors across the state. Several university-based training projects are located in Chicago as well.

## B. AGENCY CAPACITY

The State of Illinois has the capacity to provide comprehensive quality care to pregnant women, mothers and infants, children (including those with special health care needs), adolescents, and women of reproductive age through a coordinated system of services. This system is supported primarily by the programs of the Office of Family Health in IDHS, the Office of Health Promotion and the Office of Health Protection at IDPH, and the UIC Division of Specialized Care for Children (DSCC).

Statutory Base. The IDHS Office of Family Health is responsible for administration of the Maternal and Child Health Block Grant, as well as the following state statutes:

The Hearing Screening for Newborns Act requires hospitals to screen newborns for hearing loss.
The Illinois Family Case Management Act will authorize IDHS to establish and administer a program to reduce the incidence of infant mortality, very low birthweight infants, and low birthweight infants. This bill is awaiting the Governor's signature. It will replace the Infant Mortality Reduction Act.
The Problem Pregnancy Health Services and Care Act authorizes IDHS to establish projects which would assist women with problem pregnancies in obtaining services either directly or through referral.
The Prenatal and Newborn Care Act authorizes payment for prenatal care, delivery, postpartum care and "two EPSDT-equivalent screenings" of the newborn.

The Illinois Department of Public Health is responsible for the administration of the following state statutes:

The Developmental Disability Prevention Act authorizes regional perinatal health care in Illinois.
The Phenylketonuria Testing Act authorizes newborn screening for phenylketonuria, hypothyroidism, galactosemia, "and other metabolic diseases as the Department may deem necessary."
The Counties Code provides for the autopsy of children under age two years and reporting of deaths suspected to be due to Sudden Infant Death Syndrome (SIDS) b the county coroner.
The Illinois Lead Poisoning Prevention Act is comprehensive legislation regarding the use of lead in consumer products and dwellings. The law requires screening of children through age six; reporting results; the inspection and abatement of environmental lead hazards; and maintaining and providing educational materials.
The Suicide Prevention, Education, and Treatment Act authorized IDPH to carry out the Illinois Suicide Prevention Strategic Plan. When funds are appropriated, IDPH is to develop five pilot programs that provide training and direct service programs to communities. The Reduction of Racial and Ethnic Disparities Act provides grants to individuals, local governments, faith-based organizations, health care providers, social service providers and others to "improve the health outcomes of racial and ethnic populations." This bill is awaiting the Governor's signature.

The Specialized Care for Children Act in 1957 designated the University of Illinois as the agency to administer funds from "the United States Children's Bureau of the Department of Health, Education and Welfare" to support "a program of services for children who are crippled or suffering from conditions which may lead to crippling, including medical, surgical, corrective and other services and care, and facilities for diagnosis, hospitalization, and aftercare for such children."

Overview of Programs and Services. Illinois' Title V program focuses on three main areas: the reduction of infant mortality; the improvement of child health (including the health of children with special health care needs) and the prevention of teen pregnancy. Within these broad priorities are seven groups of programs: preconceptional; pregnancy; infancy and early childhood; middle childhood; adolescence; children with special health care needs; adults; and infrastructure development. Each group of programs is discussed below.

Preconceptional. The Family Planning program is the state's primary strategy for improving preconceptional health. This program provides comprehensive family planning services related to the avoidance, achievement, timing, and spacing of pregnancy. Services include client education, counseling, screening, infertility services, pregnancy testing and options counseling, contraceptive methods, and identification and treatment of sexually transmitted diseases. Services are available statewide through a network of delegate agencies. Further, Family Case Management program grantees can use a limited amount of their grant funds to provide family planning services for the medically indigent when there is no delegate agency nearby. All family planning services are provided in accordance with federal regulations for the Title X program. The Family Planning program is also supporting two male responsibility demonstration programs in Chicago.

Three other strategies are used to improve preconceptional health. The IDPH supports a statewide genetic counseling program through grants to medical centers for diagnostic, counseling and treatment services; through grants to local health departments for genetic case-finding and referral; and through grants to pediatric hematologists at medical centers that offer diagnosis, treatment, counseling and other follow-up services. The Title V program also works with the Illinois Chapter of the March of Dimes to conduct a statewide campaign promoting the consumption of folic acid. Finally, the Nutrition Services Section in the Office of Family Health lead's the state's Five A Day for Better Health initiative. An amendment to cover folic acid in IHW is pending approval.

Prenatal. The Title V program uses an array of services to improve pregnancy outcomes, including direct health care, enabling and population-based services. Direct health care services are provided through the "mini" block grant awarded to the Chicago Department of Public Health and, on a limited basis, through the Family Case Management program. (The "mini" block grant is described more fully below.) Two statewide enabling service programs are central to the Title V program's infant mortality reduction efforts: the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

and Family Case Management (FCM). The WIC program provides nutrition education and supplemental foods to pregnant or lactating women and children under the age of five from low-income families. FCM provides service coordination to low-income families with a pregnant woman or an infant.

The Title V program includes several targeted enabling service initiatives for pregnant women in particular areas or with particular health conditions. First, Targeted, Intensive Prenatal Case Management projects are placed in communities with high Medicaid expenditures during the first year of life and seek to prevent low birth weight. The number of agencies expanded from eight to 12. IDHS was awarded one of the original 15 Healthy Start projects to serve six community areas in Chicago's inner city. The Department also works with the Children's Research Triangle to support a demonstration project for identifying and treating pregnant women who use or abuse alcohol. Further, IDHS supports a demonstration projects to identify and assist women who experience domestic violence during pregnancy. The latter three projects are supported with grants from the Maternal and Child Health Bureau. IDHS continues to work with the AIDS Activity Section within IDPH to train prenatal care providers on strategies to prevent perinatal transmission of the HIV. Legislation has been passed to allow for the implementation of HIV/AIDS rapid testing and screening of pregnant women.

Finally, at the population level, IDPH now administers the state's regionalized perinatal care system. Four levels (capabilities) of perinatal care are well-defined in administrative rules: basic or Level I, intermediate or Level II, specialty or Level II+ with extended capabilities, and sub-specialty or Level III, with all facilities integrated into networks of care. Program activities focus on improving the quality of perinatal care and increasing the proportion of very low birth weight infants who are born in Level II+ or Level III centers.

Infants and Young Children. The Title V program includes enabling, population-based and infrastructure building initiatives for infants and young children. These services begin with two newborn screening programs. The state has supported a metabolic screening program for many years. The IDPH Newborn Screening Laboratory performs centralized testing on all samples and results are reported to IDPH Newborn Screening follow-up program staff. Infants with positive results for a genetic or metabolic disorder are followed through case closure or through diagnosis and initiation of treatment, and annually through 15 years of age. DSCC supports diagnostic evaluations necessary to obtain a potentially DSCC eligible diagnosis. DSCC also provided care coordination for those with DSCC eligible conditions, and financial assistance for specialty medical care if financial eligibility criteria are met. On July 1, 2002, the newborn screening program added tandem mass spectrometry testing of all newborns for amino acids, organic, and fatty acid oxidation disorders. The Newborn Hearing Screening Program is jointly administered by IDHS, IDPH and DSCC. Hospitals report all hearing screening results to IDPH. The child's parents and physician are notified of the test results and provided with an informational brochure with guidance for follow-up testing. DSCC pays for diagnostic testing if the family is unable to afford it or does not have insurance coverage for this service. Infants are referred as indicated to the CSHCN program and the Part C Early Intervention program.

The Title V program includes five statewide programs for infants and young children. The WIC and FCM programs serve low-income families with infants. FCM grantees can use a limited amount of their grant funds to pay for primary pediatric care for medically indigent children. Through performance management initiatives in the WIC program, the number of fully immunized infants has increased significantly in the last two years while the number of uninsured children has decreased. The proportion of women in WIC who breastfeed their infants and the proportion who continue to breastfeed through their infants' sixth month have doubled over the last 10 years. The IDPH Childhood Lead Poisoning Prevention Program directs the screening of children six months through six years of age, for lead poisoning, collects all blood lead test results, and provides medical case management. The IDPH Immunization Program distributes vaccine, conducts surveillance, investigates disease outbreaks, conducts educational programs, assesses vaccine coverage levels, conducts quality assurance reviews among 2,800 healthcare providers enrolled in the Vaccines for

Children Program, and promulgates regulations related to vaccination. Finally, the Title V program and the Child Care program in IDHS jointly support a statewide network of Child Care Nurse Consultants who train and consult with child care providers.

The Title V program includes or works closely with several initiatives for infants and young children with particular needs or risk factors. The High-Risk Infant Follow-up Program, a component of FCM, serves infants who have a high-risk medical condition identified through the IDPH APORS program. These infants, as well as families who experience a perinatal death, are referred to local health departments for follow-up visits by registered nurses, and follow-up may continue until the child's second birthday. The Healthy Families Illinois Program seeks to prevent child abuse and neglect through intensive home visits that provide parenting skills education to high-risk families. The HealthWorks of Illinois (HWIL) Program, another component of FCM, is a collaborative effort of IDHS and the Illinois Department of Children and Family Services (DCFS) to ensure that wards of the state receive comprehensive, quality health care. The IDPH Early Childhood Caries (ECC) program works with interested communities to establish prevention programs. The goal of the Child Safety Seat program is a reduction in automobile-related injuries and fatalities among children under the age of four. The program makes a limited number of car seats available at no charge to low-income families. Families are given hands-on instruction in the installation of the car seat. The program also works with state and local agencies to conduct car safety seat checks. The Sudden Infant Death Syndrome (SIDS) Program serves families who have experienced a sudden, unexpected infant death. Counseling and support services are offered to all families by a local public health nurse who has received training as a bereavement counselor.

The Title V program works closely with the state's Early Intervention (EI) program which provides coordinated, comprehensive, multidisciplinary services to enhance the growth and development of children from birth through 36 months of age who have developmental disabilities and delays. Services include case coordination, developmental therapy (special instruction), physical therapy, occupational therapy, speech therapy, assistive technology, nursing services, nutrition services, vision services, audiologic services and medical diagnostic services for purposes of eligibility determination. The EI program has added an infant mental health consultant in each of the 24 community-based agencies that provide intake and coordinate services for eligible families.

The Title V program includes four infrastructure development projects that affect young children. The Fetal and Infant Mortality Review (FIMR) project reviews fetal and neonatal deaths in Chicago to identify risk factors and recommend preventive interventions. The Title V program and many other interested providers and advocates are working with the Ounce of Prevention Fund on the Birth To Five Project to develop a comprehensive, coordinated, and easily- accessible system of high-quality preventive services for children before birth and through three years of age. This project's first demonstration program was the establishment of AOK Early Childhood Networks in ten communities to improve local systems of care for families with young children. The Ounce of Prevention Fund has received a grant from the Early Childhood Funders Collaborative for the Build Initiative. Illinois is one of four states to receive one of these grants.

Middle Childhood. The Title V program includes several programs for children in middle childhood. The Vision and Hearing Screening Program administered by IDPH supports screening activities by local health departments, school districts or other contractors to identify children with possible problems. IDPH also coordinates ophthalmologic, optometric, otologic, and audiologic examination clinics throughout the state. The Dental Sealant Grant Program (DSGP) works with interested communities to establish school-based programs for dental sealant applications. Coordinated School Health Program grants are provided to 12 local health departments and school districts to promote utilization of a Coordinated School Health Program model for students in grades K-12. The School Health program provides comprehensive consultation and technical assistance to schools throughout the state. Professional continuing education programs (School Health Days and Critical Issues Conferences) for qualified school and public health nurses, social workers, health educators, and school administrators are conducted annually. School-Based/School-Linked Health Centers provide health care services to students enrolled in 15 elementary and 11 middle schools. In collaboration

with the IDPH Division of Oral Health, centers are serving as pilot sites to implement an oral health education curriculum into grades K-12. Two childhood asthma demonstration projects in Chicago use peer or community health educators to empower communities to deal with this complex health issue.

Adolescents. The Title V programs for adolescents include direct health care services through school-based health centers; projects to prevent teen pregnancy; family support programs for pregnant and parenting teens; and youth development programs. The School-Based/School-Linked Health Centers promote healthy lifestyles through health education and comprehensive direct physical, dental, and mental health services. Services are provided within or nearby the schools by licensed professional staff or through referral to other local health care providers. Health centers that meet established standards are enrolled as Medicaid providers. The School-Based Health Centers engage in Continuous Quality Improvement (CQI). The professional staff currently assesses each patient for overweight and other health problems. Health center staff then identify and implement health education, health promotion and interventions in these areas.

The Teen Pregnancy Prevention Program provides support for community-based planning through a combination of community collaboration among partners to enrich primary prevention and improve access to health services for adolescents. Local programs focus their efforts on at least two of the following program components: sexuality education, family planning information and referral, male involvement, youth development, public awareness, or parental involvement.

Title V also includes four programs for teen parents. The Teen Parent Services (TPS) program is mandated for young parents (under age 21) who are receiving or applying for TANF and who do not have a high school diploma or its equivalent upon entry into the program. It is offered to young parents who receive Medicaid, WIC, FCM, or Food Stamps. TPS assists the young parents to enroll and stay in school, and results in a young parent who is better prepared to make the transition from TANF or other public benefits to economic self-sufficiency. The program also assists any pregnant/parenting teen to access other IDHS programs and benefits. The Parents Too Soon (PTS) program helps new and expectant teen parents to develop nurturing relationships with their children, reduce the rate of subsequent pregnancy, improve their own health and emotional development, and promote the healthy growth and development of their children. Services include weekly home visits and monthly peer group meetings. The Responsible Parenting program assists adolescent mothers who are between 13 and 18 years of age to delay subsequent pregnancies, consistently and effectively practice birth control, continue their schooling to high school graduation, develop parenting skills and to cope with the social and emotional problems related to pregnancy and parenting. Finally, a doula, or birthing assistant, is a woman who provides emotional support to a woman throughout the antepartum and postpartum periods. Five program sites provide doula services beginning in the third trimester of pregnancy and continuing through the first three months following birth.

There are four youth development programs in the Office of Family Health's Bureau of Child and Adolescent Health and the IDHS Office of Prevention. Within the Office of Family Health, the Youth Opportunity Program focuses on children who are TANF- eligible or other low-income families to help them break the generational cycle of welfare dependency and help prevent school dropout, unwanted pregnancies, and gang involvement. Students receive career development training and individual, group and family counseling.

The Office of Prevention's Bureau of Youth Services and Delinquency Prevention offers community-based out-of-school time programming, as well as a comprehensive array of prevention, diversion, intervention, and treatment services targeting youth to stabilize families in crisis, prevent juvenile delinquency, and divert youth at risk of involvement in the child welfare, juvenile justice, or correctional systems. The Bureau of Community-Based and Primary Prevention funds community-based prevention initiatives and prevention training and education for youth in the areas of abstinence education, substance abuse prevention and volunteerism and community service. The Bureau's programming fosters the development of positive lifestyles and the reduction of substance abuse in Illinois through outcome/evidenced-based planning and programming.

Children with Special Health Care Needs. The Title V program for children with special health care needs (CSHCN) is operated by the University of Illinois at Chicago's Division of Specialized Care for Children (DSCC). It serves approximately 23,000 children annually through the Core Program, the IDHFS Home Care Waiver Program, the SSI Disabled Children Program, and the Children's Habilitation Clinic.

The goal of DSCC's Core Program is to assure community based, family centered, and culturally sensitive provision of comprehensive care coordination services for eligible CSHCN and their families. Core Program services include comprehensive evaluation, medical care coordination and related habilitative services appropriate to the child's needs and financial support of such care, subject to financial eligibility. The program serves children with impairments associated with the following categories: orthopedic, nervous system, cardiovascular, craniofacial deformities, hearing, organic speech, cystic fibrosis, Hemophilia, inborn errors of metabolism, eye and urinary system. The program provides care coordination services for approximately 20,000 children annually.

Initial diagnostic evaluation services are provided in part by a network of more than 60 field clinics administered and funded by DSCC, as well as private physicians and other freestanding clinics. The clinic system allows medical specialists and professional staff to provide diagnostic evaluation and treatment of children with medical conditions eligible for DSCC services, assisting children to access specialists not available in their communities.

DSCC has a network of 13 regional offices with care coordinators (nurses, social workers, and speech pathologiest/audiologists) that develop an Individual Service Plan (ISP) for each child following the initial evaluation process to specify the care coordination services needed and the financial support required for treatment. The ISP reflects the perceived needs and priorities of the child and family, the medical needs as articulated by the managing physician and the plan by which the needs will be addressed.

Children receive diagnostic and care coordination services without regard to a financial means test. Families of those children requiring financial support for treatment services must demonstrate a total income below 285 percent of the federal poverty level adjusted for family size. All families must utilize existing health insurance benefits before financial assistance can be provided. Children with severe, long-term disabilities receive continued DSCC care coordination assistance regardless of family income. Families of uninsured CSHCN who meet KidCare financial requirements are required to apply and enroll (if eligible) in KidCare in order to continue financial assistance from DSCC. Children receiving KidCare receive care coordination to assist them in accessing services and limited financial assistance for services not covered by KidCare.

DSCC operates the Title XIX Waiver for Home and Community-Based Services for Medically Fragile/Technology Dependent Children, which is administered through the IDHFS. The program provides cost-effective care coordination and supportive home services to children with complex medical needs who would otherwise be at risk of prolonged institutionalization or re-institutionalization in a hospital or long-term care facility. Beginning with FFY'05, the costs associated with this program have been excluded from the budget and expenditure reports in Forms 2, 3, 4 and 5.

DSCC is the agency designated to administer the Supplemental Security Income- Disabled Children's Program (SSI-DCP). Children are determined to be eligible for this program through the Illinois Disability Determination Services (IDDS), which, in turn, refers SSI medically eligible children to DSCC for further assistance. DSCC receives information on approximately 280 SSI-eligible children a month who are under 16 years of age.

DSCC provides information and referral services to these SSI-eligible children by sending comprehensive profiles on state/local programs, including the DSCC Core Program, which may benefit the child or family. Families may request information in Spanish. Additionally, a toll-free 800 number is provided to all families to access further information and additional assistance. An application is sent to families with a child who may be eligible for DSCC services and the appropriate

Regional Office provides referral follow-up. Through telephone contact, DSCC staff links those children under the age of five years to Part C Early Intervention, Part B Early Childhood, and Pre-Kindergarten for Children at Risk as appropriate. DSCC telephones families with children ages three to four to offer assistance in linking to appropriate resources.

The Children's Habilitation Clinic is located within the Children and Adolescent Center of the Outpatient Care Center, the University of Illinois at Chicago's comprehensive outpatient facility. This location allows clinic staff to collaborate with other subspecialists and with primary care physicians and nurse practitioners. Staff provides comprehensive diagnostic services for children with complex disabling conditions and developmental management to those children through age 21. For all second-year pediatric and medical residents at UIC's School of Medicine, and other health care students, the clinic also provides a required rotation in the care of children with disabilities. There are approximately 1,600 patient visits annually. DSCC cosponsors the Institute for Parents of Preschool Children Who are Deaf or Hard of Hearing with IDPH, IDHS, the Illinois School for the Deaf, and the Illinois State Board of Education. This is a weeklong educational program for parents of children, ages birth to five, who have a significant hearing loss. The Institute provides an opportunity for parents to learn about deafness and their child's individual strengths and needs, as well as meet other parents who have children with hearing loss. At the conclusion of the Institute, parents meet with staff to discuss evaluation results and treatment recommendations and to plan for the future. The Institute for Parents of Preschool Children Who are Deaf or Hard of Hearing also provides multidisciplinary evaluations.

DSCC is collaborating with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), the Illinois Academy of Family Physicians, and the Shriners Hospitals for Children to identify and train Primary Care Physicians (PCP) to serve as the Medical Home Providers for CSHCN who participate in the Title V program. In order to be enrolled in DSCC, Medical Home Providers are required to complete a Continuing Medical Education (CME) Monograph on Medical Home (within six months of application), in addition to being board certified as a pediatrician or family physician and meeting the other DSCC general provider criteria. PCPs who complete training (and meet DSCC's general criteria) are able to bill for care coordination activities, follow-up on medically eligible conditions as agreed upon by the specialist, and telephone consultation, if needed with a pediatric facilitator or specialist. DSCC care coordinators assist in facilitating communication and reports among the providers involved with the individual child.

DSCC is represented on the Illinois Interagency Council on Early Intervention (IICEI). Care coordination is provided for families with children jointly enrolled in DSCC and Early intervention (EI) program. Financial assistance is provided for specified medical services for families who are financially eligible (i.e., surgery, medications, durable medical equipment and supplies).

As a member of the Illinois Interagency Coordinating Council on Transition, DSCC is collaborating to develop a statewide plan to improve access to and availability of comprehensive transition services. Other members of the Council represent state agencies in the following areas: education, corrections, employment/training, health, and human services.

DSCC, in collaboration with MCHB's Division of CSHCN, has developed and published a newsletter, Special Addition, containing articles of national and state interest. Illinois continues to coordinate the family newsletter template with more than 30 other states.

Adults. The Title V program supports or collaborates with several programs for adults. The Illinois Fatherhood Initiative conducts several activities to promote fathers' active participation in their children's lives. Parents Care and Share of Illinois conducts support groups across the state for parents. The Office of Prevention's Bureau of Domestic and Sexual Violence Prevention administers domestic violence and sexual abuse prevention programs throughout the state, offering comprehensive, community-based services that meet the immediate and long-term needs of victims and their children.

Infrastructure Building. Finally, the Title V program includes several infrastructure-building initiatives. The Chicago MCH Mini-Block Grant to the Chicago Department of Public Health (CDPH) supports direct and enabling services to pregnant women, children, and women of reproductive age. The Department works with the UIC School of Public Health to conduct several leadership development programs for state and local Title V program staff.

## C. ORGANIZATIONAL STRUCTURE

As described in previous MCH Services Block Grant Applications, the Governor has designated the IDHS as the state health agency responsible for the administration of the MCH Services Block Grant. Through an interagency agreement, MCH Block Grant funds are transferred to the IDPH for the administration of the Vision and Hearing Screening, Oral Health, Genetics, Childhood Lead Poisoning Prevention and Perinatal Care programs. In compliance with federal law, IDHS transfers 30 percent of Illinois' MCH Block Grant funds to DSCC for services to CSHCN. Copies of current interagency agreements are on file in the Office of Family Health. Additional information about the structure of these three agencies is presented below.

The Illinois Department of Human Services. The IDHS is organized into six divisions. The Division of Community Health and Prevention (DCH&P) includes the MCH program, substance abuse prevention, domestic violence prevention and intervention, sexual assault prevention and response, youth services, and delinquency prevention. The Division of Developmental Disabilities includes the Supplemental Security Income Disability Determination Service, as well as programs for persons with developmental disabilities. The Division of Human Capital Development includes adult employment, income assistance, food and shelter, refugee services, child care, and special social service projects and is responsible for the Department's local offices. One or more local offices are located in almost every county of the state. Staff in these offices perform intake and eligibility determination for cash assistance, Food Stamps, Medicaid, SCHIP, and other programs. The Division of Alcoholism and Substance Abuse is responsible for substance abuse treatment services. The Division of Mental Health is responsible for the state's system of community-based mental health care as well as psychiatric hospitals. The Division of Rehabilitation services oversees the state's system of care for persons (mostly adults) who are physically challenged.

The Division of Community Health and Prevention is organized into two offices: the Office of Prevention and the Office of Family Health. The Office of Prevention promotes and implements programs to address critical issues that affect the health and well-being of families. A wide range of comprehensive prevention efforts, designed to prevent domestic violence, alcohol, tobacco and other drug abuse, and juvenile delinquency are implemented through coordinated, innovative community-based strategies.

The Office of Family Health has primary responsibility for the MCH program. The mission of the Office of Family Health is to promote and improve the health status, economic self-sufficiency and integrity of families in Illinois by advocating for and assuring the availability and accessibility of comprehensive health and social services.

This mission is accomplished through the activities of the Bureau of Maternal and Infant Health, the Bureau of Child and Adolescent Health, and the Bureau of Family Nutrition. These bureaus have established a statewide network of comprehensive, community- based systems of health and social services for women of reproductive age, infants, children and adolescents to assure family-centered, culturally competent and coordinated services. The Bureau of Maternal and Infant Health is responsible for the Family Planning, Family Case Management, Chicago Healthy Start, Targeted Intensive Prenatal Case Management, Closing the Gap, HealthWorks, Pediatric Primary Care, High-Risk Infant Follow-up, Doula, and Fetal and Infant Mortality Review programs, as well as the "Mini Block Grant" to the Chicago Department of Public Health. The Bureau of Child and Adolescent Health is responsible for the Teen Parent Services, Parents Too Soon, Healthy Families Illinois, Teen Pregnancy Prevention, and Responsible Parenting programs. The Bureau of Family Nutrition is responsible for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC),

the Commodity Supplemental Foods Program, 5-A-Day for Better Health, Folic Acid, the Diabetes Prevention and Control Program (funded with a grant from CDC), and WIC and Senior Farmers' Market Nutrition Program.

The office of the Associate Director for Family Health oversees the state's early childhood and school health programs, as well as several demonstration projects. The early childhood initiatives include the State Early Childhood Comprehensive Systems Initiative and the All Our Kids Early Childhood Networks. The School Health program includes the Coordinated School Health program, School-Based Health Centers and continuing education programs for school health personnel. The office of the Associate Director also oversees the leadership development programs supported by the State Systems Development Initiative.

The MCH program is supported by five other units: the Nutrition Services Section in the Bureau of Family Nutrition; the Bureau of Community Health Nursing in the Office of Family Health; the Bureau of Performance Management Services and Support, the Bureau of Community Support Services, and the Bureau of Fiscal Support Services. The role of each of these units is described below:

The Nutrition Services Section in the Bureau of Family Nutrition is comprised of regional nutrition consultants, a state breastfeeding coordinator, and a state nutrition coordinator. All are masters-prepared Registered Dieticians with expertise in maternal and child health. The section provides consultation and technical assistance on nutrition issues for the WIC and other maternal and child health programs.

The staff of the Bureau of Community Health Nursing (BCHN) work to ensure that the services provided by MCH program grantees are of high quality. The BCHN is composed of masters-prepared Maternal and Child Health Nurse Consultants who are geographically distributed throughout the state. The MCH Nurse Consultants develop and present in-service training, continuing education programs, and technical assistance for local agency staff. The BCHN is also responsible for two programs: the Healthy Child Care Illinois and the Asthma Education Program.

The Division of Community Health's Bureau of Performance Support Services (PSS) performs a variety of activities related to the collection, maintenance, and evaluation of community health and prevention data, and the development and presentation of training sessions to enhance the skills of prevention service providers.

The Bureau of Community Support Services performs contract monitoring and helps local program grantees integrate their services in order to respond effectively to community needs.

The Division of Community Health and Prevention's Bureau of Fiscal Support Services provides accounting for the Division's financial resources and the Bureau of Community Support Services provides technical assistance and performs contract compliance monitoring for all of the Division's programs.

Information and Referral Helpline. MCH Helpline staff answer three 800 lines: 1) 800-323-GROW/4769; 2) 800-545-2200 (MCH); and 3) 800-843-6154, option #5 (DHS Customer Service Line). The staff of four fields about 4,000 calls per month, including 300 Spanish-speaking calls. The MCH Helpline staff handle calls on a wide variety of health and human service needs. The Helpline also has a counselor on staff to take calls that require extended active listening prior to referring the caller on to appropriate local services. About 65 percent of callers are from the general public, and about 35 percent are local agency personnel.

The Illinois Department of Public Health. As a result of the reorganization of state human service agencies in 1997 (Public Act 89-0507), IDPH retains responsibility for the following statutes and MCH programs: the Phenylketonuria Testing Act, which supports the newborn metabolic screening program; the Counties Code, which supports the Sudden Infant Death Syndrome program; the Illinois Lead Poisoning Prevention Act, which supports the Childhood Lead Poisoning Prevention Program;

and the Prevention of Developmental Disability Act, which supports the perinatal care program. IDPH also operates the Vision and Hearing Screening Program and the Oral Health Program. IDPH assumed sole responsibility for the Perinatal Care programs in SFY'05. IDHS and IDPH annually execute an interagency agreement regarding the coordination of MCH services provided or funded by each agency.

The University of Illinois at Chicago Division of Specialized Care for Children. The University of Illinois at Chicago (UIC) Division of Specialized Care for Children (DSCC) administers the CSHCN program. DSCC is staffed to accomplish its traditional role of providing care coordination, facilitating financial support for needed services, and advocating for high quality specialty services for CSHCN. Through a network of 13 regional offices and more than 60 satellite locations, DSCC maintains a strong focus on capacity building through family-centered, community-based care coordination activities and local systems development within all 102 counties in Illinois.

The Director of DSCC has available consultation and assistance from a major state university, including a School of Public Health, Colleges of Medicine, Nursing, Associated Health Professions and Education, as well as numerous associated health facilities and programs. A statutory Medical Advisory Board composed of medical community leaders from across the state and a family representative meet three times per year to counsel the Director on program policy and activities. In addition, consultation and assistance is also available from the DSCC Family Advisory Council (FAC) which meets three times per year and has family member representation from all 13 regions of the state. The FAC Chairperson also serves as the family member representative on the DSCC Medical Advisory Board.

Frequent, close liaison is maintained with all major public and private agencies involved in services for CSHCN. DSCC has leadership and/or membership involvement with the following CSHCN-related programs or activities: Illinois Chapter of the American Academy of Pediatrics Committee on Children with Disabilities, the Illinois Academy of Family Physicians, the Illinois Maternal and Child Health Coalition, Illinois Interagency Council on Early Intervention, Birth to Five Project State Work Group, Illinois Interagency Transition Consortium, Brain and Spinal Cord Injury Advisory Council, Illinois Universal Newborn Hearing Screening Advisory Committee, Illinois Genetics and Metabolic Diseases Advisory Committee, Illinois Campaign for Better Health (State Children's Health Insurance Program Work Group), Illinois Department of Public Health Hearing Screening Advisory Board, Illinois Department of Public Health Vision Screening Advisory Board, Department of Human Services School Health Advisory Board, Hearing Impaired Behavior Disorder Advisory Board, Illinois Interagency Advisory Council for Deaf and Blind, Healthy Child Care Illinois Steering Committee, the UIC-SPH MCH Training Program, and Illinois Hemophilia Advisory Council. DSCC meets on an "as needed" basis with Family Voices. DSCC also has collaborative activities with Shriners Hospitals for Children in Chicago and St. Louis.

In addition to senior DSCC staff participation on interagency boards, councils and task forces at the state level, regional office staff have developed and participate in numerous community working groups which involve local leaders and parent groups. These activities are exemplified by the regional staff involvement in the AOK Early Childhood Networks, Early Intervention Local Interagency Councils and Transition Planning Committees.

For additional information, please visit the DCHP web site (www.dhs.state.il.us/chp), the DSCC web site (www.uic.edu/hsc/dscc) or the IDPH web site (www.idph.state.il.us).

## D. OTHER MCH CAPACITY

IDHS. There are a total of 140 FTE positions in the Department's MCH program. There are 55 FTE positions at the central office in Springfield. Regional staff are deployed as follows: Region 1 (Chicago), 54 FTEs; Region 2 ("collar counties" and northern Illinois) eight FTEs; Region 3 (north

central Illinois) nine FTEs; Region 4 (south central Illinois) five FTEs; and Region 5 (southern Illinois) nine FTEs. Regional staff are generally Masters-prepared maternal and child health nursing consultants, nutrition consultants and regional representatives involved in quality assurance and technical assistance. Central office staff includes 27 FTE professional and technical positions, and 19 FTE support staff positions. Statewide, the professional staff includes 21 registered nurses, 11 registered dieticians, and two social workers. At the time this application was submitted, 47 full-time positions were vacant.

Ralph M. Schubert, M.Sc., M.A., is the IDHS' Acting Associate Director for Family Health in the Division of Community Health and Prevention. In this capacity, he is responsible for planning and directing the State of Illinois' Maternal and Child Health Program. Before assuming the position of Acting Associate Director, Mr. Schubert served for two years as the Acting Chief of the Bureau of Program development and Health Support in the Office of Family Health, which oversees early childhood and school health programs, grant writing, demonstration projects and office operations. For twelve years before that, he oversaw the MCH Grants and Program Development Unit, which was responsible for writing grants to support MCH programs and implementing various demonstration projects. Prior to that, Mr. Schubert managed the downstate "Families with a Future" (Infant Mortality Reduction Initiative) grants and developed the program evaluation. He has 19 years of experience in Maternal and Child Health at the state level, and an additional six years of experience in chronic and communicable disease programs at the state level. He holds a Master of Science degree in Administration and Organizational Behavior from George Williams College and a Master of Arts degree in Human Development Counseling from Sangamon State University.

DSCC. DSCC employs 202 FTEs to provide enabling services from local offices within the DSCC regional office system. Ninety FTEs in the Springfield Central Administrative Office provide necessary infrastructure support (system/policy development, core program technical assistance, administrative support, fiscal and information management, and personnel services) for the regional offices' care coordination system. An additional administrative office on the UIC campus accommodates six FTEs who provide Home Care Waiver Program technical assistance and administrative support activities. The administrative staffing in the Springfield Central Administrative office has been reduced by eight percent as a result of budget cuts. With those reductions, the available number of staff (administrative support, fiscal management, information systems support, and human resources) to support services to the field office care coordination staff have been impacted. Additionally, statewide all part-time/temporary positions have been eliminated and overtime has been limited to support clinics and emergency situations with minimal impact in providing assistance to families. DSCC also provides direct services through the Children's Habilitation Clinic at UIC, which is staffed by five FTEs, including a developmental pediatrician, a clinical practice nurse specialist, clinical psychologist, medical social consultant, and support staff. Ancillary services such as physical therapy and speech pathology are obtained through contracts.

Charles N. Onufer, M.D., is the DSCC Director. In this capacity, he is responsible for planning and directing the State of Illinois' Program for Children with Special Health Care Needs. Dr. Onufer serves as Chairman of the Illinois Chapter of the American Academy of Pediatrics Committee on Children with Disabilities and also on other state Committees, including the Illinois Interagency Coordinating Committee on Transition, the Genetic and Metabolic Disease Advisory Committee, Vice President of the Brain and Spinal Cord Injury Advisory Council, Co-Chairman of the AMCHP Best Practices Committee, Chairman of the Medical Home Work Group for HRSA Region IV Genetics Collaboration Committee, and is on the Planning Committee for the annual national MCH Leadership Conference Translating Research into Practice, implemented by the UIC-SPH Maternal and Child Health Program. Dr. Onufer is collaborating with over 30 other CSHCN programs to publish a biannual family newsletter, Special Addition, for families. Dr. Onufer is a Board-certified Pediatrician, a Fellow of the American Academy of Pediatrics, and an Assistant Professor of Pediatrics at UIC. He received his Doctor of Medicine degree from Ohio State University and completed his pediatric and fellowship training from Tripler Army Medical Center and Madigan Army Medical Center, respectively.

## E. STATE AGENCY COORDINATION

For a description of the organizational relationship among Illinois' human services agencies directly involved in the Title V program please refer to Organizational Structure. Interagency agreements among IDHS, IDPH and DSCC are on file at the Office of Family Health's headquarters in Springfield.

IDHS, IDHFS, and IDPH are strengthening the state infrastructure for program planning and development through a three-way agreement for exchange of data for program planning, monitoring and evaluation. The agreement involves the exchange of vital records, Medicaid eligibility and service delivery, MCH and other program management data.

The Family Case Management Act (passed by the Illinois General Assembly on May 27, 2005 and awaiting the Governor's signature) requires the Department to create a Maternal and Child Health Advisory Council. This new council will strengthen state, regional, and local relationships for the coordination and integration of Title V with other state and federal programs.

IDHS and DSCC collaborate to implement a variety of programs to serve the MCH and CSHCN populations. This collaboration includes both informal and formal linkages for service delivery.

Other Divisions Within The Illinois Department of Human Services. To enhance continuity of care for CSHCN, DSCC collaborates with IDHS' Division of Rehabilitation Services (DRS) in the following areas that benefit CSHCN: vocational rehabilitation services for clients at or near employable age; home services programs to avoid unnecessary institutionalization; education and habilitative services for children requiring education programming outside their communities; independent living programs; referral process for children determined medically eligible for SSI, and transition of DSCC Home Care Waiver children to the DRS home-based waiver program.

Through systems change efforts, DSCC and DRS have increased collaborative efforts targeted at transition planning for CSHCN. Additionally, a three-agency agreement is being developed between DSCC, DRS, and IDHFS to facilitate the transition of children from the waiver for medically fragile, technology dependent children operated by DSCC to the Home Service Program, which is another Home and Community-Based Services waiver operated by DRS for persons with disabilities through age 59.

DSCC maintains a Memorandum of Understanding with the Early Intervention Program to coordinate activities, including referral between the two programs.

The Office of Family Health (OFH) collaborates with other Divisions within IDHS to improve the coordination and effectiveness of Title V programs as follows:

OFH and the Division of Human Capital Development collaborate to help TANF families move from welfare to work through intensive casework services that connect them to IDHS programs and benefits they need, and to local community resources where other services are provided.
OFH and the Division of Mental Health collaborate to promote the integration of service systems in order to provide a comprehensive array of mental health and support services to children and their families.
OFH and the Division of Alcoholism and Substance Abuse collaborate to coordinate and fund community-based services throughout the state for the prevention, intervention, treatment, and rehabilitation of alcohol and other drug abuse and dependency for at-risk or addicted individuals and their families.

Through an interagency agreement, the Illinois School for the Deaf, Early Intervention, Illinois Department of Public Health, Illinois State Board of Education, and DSCC collaborate to provide the annual Institute for Parents of Preschool Children Who Are Deaf or Hard of Hearing, to enhance the knowledge of parents of infants and toddlers and provide multi-disciplinary evaluation. In 2004 and 2005, DSCC provided family scholarships to families who attended the Institute to offset the weeklong

commitment.

IDHS and DSCC coordinate with other State agencies as noted below.

Illinois Department of Healthcare and Family Services. IDHS and IDHFS have an Interagency Agreement for the coordination of Title V, Title XIX, and Title XXI program activities. This agreement allows each agency to refer eligible clients to the other for services. The two agencies have a separate agreement for the Family Case Management initiative that enables IDHFS to claim federal matching funds through the Medicaid program for outreach and case management activities conducted by the Family Case Management program. IDHS and IDHFS have arranged for local health departments to claim federal matching funds through the Medicaid program for local expenditures that support the Family Case Management program. For SFY'04, $6.6 million in federal matching funds have been reimbursed to local health departments. Ninety local health departments are participating through intergovernmental agreements.

Local MCH programs, including local health departments, family planning clinics, and WIC agencies are serving as outstations for determining eligibility of pregnant women and initiating the KidCare (Title XIX and Title XXI) application process for children under 19 years of age. An annual notice is mailed to all families eligible for Title XIX or Title XXI (except individuals residing in long-term care facilities) to inform them of the WIC program and provide them with the Department's Health and Human Services hotline number. The last notice was sent on September 9, 2004. The next notice is planned for July 2005.

IDHFS maintains an interagency agreement with DSCC. The agreement is annually reviewed and updated as needed. It includes a description of each agency's responsibilities in implementing the home and community-based services (HCBS) Section 1915 (c) waiver for medically fragile, technology dependent children under the age of 21. The DSCC responsibilities in the day-to-day operations of the HCBS waiver are outlined in detail in the agreement. DSCC provides care coordination, follows State and federal rules, and conducts quality assurance activities including oversight of nursing agencies and providers of durable medical equipment that serve the children in the waiver. DSCC also acts as a KidCare application agent. DPA funds the program and maintains final approval of waiver eligibility, plans of care, and hearing decisions. This agreement also facilitates claiming FFP for care coordination services for Medicaid-eligible children in the Core Program.

Illinois Department of Public Health. IDHS works with many divisions and programs within IDPH to develop preventive and primary care systems. IDPH and DSCC provide otologic/audiologic clinics in communities with high rates of children who receive no follow-up after failure of school hearing screenings. A Memorandum of Understanding delineates collaborative activities for children identified through the Newborn Metabolic Screening, Genetic Counseling, Vision and Hearing Screening, and Hearing Instrument Consumer Protection.

IDPH, IDHS, and DSCC collaborate on the state's Universal Newborn Hearing Screening Program to enhance system development and implementation. DSCC has taken on responsibility for system development activities related to this program. DSCC applied for and received the Universal Newborn Hearing Screening and Intervention Grant.

In 1999, the Illinois Department of Public Health received funding from the U.S. Centers for Disease Control and Prevention to build capacity and to develop a state plan to address asthma. As a result, the Illinois Asthma Program was formed and a statewide partnership was developed. The Partnership meets semi-annually, in addition to annual regional trainings and a yearly asthma conference. Five work groups and community asthma coalitions assist with the partnership's efforts. The Illinois Asthma Program (IAP) funds four coalitions to implement asthma state plan goals and funds a number of communities to develop asthma coalitions to begin to address asthma for World Asthma Day and funded 29 WIC clinics to provide asthma education to staff and clients.

IDHS works in collaboration with the IDPH's Illinois Asthma Initiative. The MCH program is

represented at the advisory level and on the statewide subcommittees by MCH Nurse Consultants, Child Care Nurse Consultants, and School Health staff. Activities in 2005 include the distribution of asthma toolkits to child care providers. The Healthy Child Care Illinois nurse consultants ensure the distribution of the toolkits and will provide education about asthma. Other activities include offering an asthma calendar contest for Illinois fifth and sixth grade students and hosting an annual satellite program, which focused on a comprehensive approach to asthma management in schools. The program was held to educate school staff and parents on the management of asthma and the various components (roles of school staff, physical activity, medications and action plans and environmental and pest management issues) of an asthma management plan.

Illinois State Board of Education (ISBE). Although there is no formal agreement with the ISBE, program staff from the DSCC central office coordinate with State Board staff regarding issues for CSHCN in schools. DSCC distributes to families via its regional offices, "A Parent's Guide: The Educational Rights of Students with Disabilities," published by ISBE. DSCC regional office staff coordinate with the local schools regarding individual issues in the educational setting.

ISBE no longer employs a school health consultant and refers questions on school health related issues to the IDHS School Health program staff and to the appropriate programs within IDPH. The School Health program staff worked with the ISBE and a State Advisory Committee to publish numerous documents, including: Recommended Guidelines for a Medication Administration in Schools; Asthma Management: A Resource Guide for Schools; Diabetes in Children: A Resource Guide for School Health Personnel; First Aid Procedures for Injuries and Illnesses; Certificate of Child Health Examination; and Health Status of School Age Children and Adolescents in Illinois. Copies of these documents have been sent to all public and private schools in the state, as well as advocacy groups and individuals interested in these issues. The documents are also available electronically on the DHS School Health Program web page. ISBE staff assist in the review of applicants for new school-based/school-linked health centers and coordinated school health program grants.

Schools. A variety of programs are operated through schools to meet the needs of children and adolescents. First, the school-based and school-linked health centers work through primary care providers to deliver comprehensive medical, mental health and preventive health education services to school-age children and parenting students. These clinics coordinate care provided to their clients with the clients' primary care provider. The clinics refer the client for specialty care as needed and seek third party reimbursement for services provided. Second, IDHS works with 12 local health departments to implement coordinated school health programs. Third, the MCH program also conducts continuing education programs for school nurses. Finally, schools are also the main delivery sites for the Unmarried Parents and Youth Opportunity programs.

Illinois Department of Children and Family Services. DSCC collaborates with the Illinois Department of Children and Family Services (DCFS) on behalf of state wards of DCFS who have special health care needs and are eligible for DSCC services. Coordination activities include identifying referral mechanisms for sharing information. To enhance system collaboration, DSCC staff provide in-service training on CSHCN to local and regional DCFS staff throughout the state. MCH program staff work with DCFS on the management of HealthWorks of Illinois, described earlier in this application.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

Data for Health Systems Capacity Indicators 1 through 9 are presented on Forms 17, 18, and 19.

Prenatal Care. The proportion of women who initiate prenatal care in the first trimester of pregnancy has been steadily improving in Illinois; the proportion reached 82.8 percent in 2002 and declined slightly to 82.0 percent in 2003 (see Federal Performance Measure 18). Similarly, the proportion of women who receive an adequate number of prenatal care visits has been steadily increasing as measured by either the Kessner Index (see State Performance Measure 1) or the Kotelchuck Index

(see Health System Capacity Indicator 4 on Form 17). In 2003, 74.4 percent of women who gave birth received an adequate amount of prenatal care as measured by the Kessner Index, and 78.2 percent received an adequate amount of prenatal care as measured by the Kotelchuck Index. The proportion with adequate prenatal care on the Kessner Index fell slightly from 2002 (75.1 percent) but improved on the Kotelchuck Index (77.5 percent).

Pregnant women with family incomes at or below 200 percent of the federal poverty level are eligible for services under either Medicaid or SCHIP (Healthy System Capacity Indicator 6 on Form 18). Eligibility for children under SCHIP is 200 percent of the federal poverty level. Parents and other caretakers are currently eligible for FamilyCare up to 185 percent of the federal poverty level; eligibility for parents and other caretakers will increase to 185 percent of the federal poverty level in January 2006.

Medicaid-eligible pregnant women are less likely than non-Medicaid-eligible women to initiate prenatal care in the first trimester of pregnancy (72.7 percent versus 90.2 percent in 2003, Health Systems Capacity Indicator 5c, Form 18) and less likely to have an adequate number of prenatal care visits (69.8 percent versus 85.5 percent in 2003, Health System Capacity Indicator 5d, Form 18).

First trimester initiation of prenatal care among Medicaid-eligible women who participated in the WIC or FCM programs was higher (74 percent) than the rate among women who didn't participate in either program (65.9 percent) in 2003. Similarly, a greater proportion (65.3 percent) of Medicaid-eligible pregnant women who participated in either WIC or FCM received an adequate number of prenatal care visits when compared to women who didn't participate in either program (54.2 percent) that same year. The Department will continue to invest resources in programs to promote early and continuous prenatal care, including WIC, FCM, Healthy Start, Targeted Intensive Prenatal Case Management and the new Closing the Gap initiative.

The IDHFS convened a task force to examine the feasibility of adding optional Medicaid perinatal support services to Illinois' plan. The task force's recommendations were discussed in Section III A (State Overview) of this application. The Report to the General Assembly on Public Act 93-0536 is located at www.hfsillinois.com/mch/report.html.

Infants. The proportion of Medicaid-eligible infants who obtain routine well-child care has been steadily improving in Illinois. The proportion has exceeded 90 percent for the last five years and reached 93.7 percent in 2004 (Health Systems Capacity Indicator 2, Form 17). The high rate of utilization reflects the effort of several MCH programs to ensure that infants obtain appropriate well-child care. Until 2004, fewer than 300 infants a year were eligible for SCHIP for at least 30 days. Enrollment in SCHIP improved in 2004, and almost 90 percent of these infants received at least one well-child service. This small number of eligible children limits the interpretation of the rate of well-child care utilization in this population (Health Status Indicator 3, Form 17). Most of the infants identified through the KidCare program are found to be eligible for Medicaid.

Infants from families with incomes below 200 percent of the federal poverty level are eligible for health insurance coverage through either Medicaid or SCHIP. Infants who were born to a Medicaid-eligible woman are covered through the first year of life on the Medicaid program. Otherwise, infants from families with incomes below 133 percent of the federal poverty standard are eligible for Medicaid (Health Systems Capacity Indicator 6a, Form 18).

Similar to the pattern observed for pregnant women, the rates of low birth weight and infant mortality were higher among Medicaid-eligible infants (9.5 percent and 7.7 per 1,000, respectively) than non-Medicaid-eligible infants (7.3 percent and 6.9 per 1,000, respectively). (Refer to Health Status Indicators 5a and 5b on Form 18). Further, infants born to Medicaid-eligible women who participated in either WIC or FCM had lower rates of infant mortality and low birth weight (8.7 percent and 5.8 per 1,000 respectively). Participation in MCH programs has a significant effect on the health of low-income pregnant women and infants.

Children. Appropriate care of asthma in young children and access to oral health care are two persistent health care system problems in Illinois. In 2002, the rate of asthma hospitalization among children under five years of age decreased to 64.4 per 10,000, the lowest level in the last five years. The MCH program supports two demonstration projects to improve asthma management in young children; these activities were described earlier in the application. In addition, the MCH program participates in several initiatives of Illinois Department of Public Health to reduce the burden of childhood asthma. The proportion of Medicaid-eligible children between six and nine years-of-age who received any dental services improved from 2002 (Health Systems Capacity Indicator 7, Form 17). Children over one year-of-age from families with incomes below 133 percent of the federal poverty level are eligible for Medicaid; children from families with incomes between 133 and 200 percent of the federal poverty standard are eligible for SCHIP (Health Status Indicator 6, Form 18).

Children with Special Health Care Needs. For a description of DSCC's efforts for SSI-eligible children, see B. Agency Capacity, Children with Special Healthcare Needs (Health Systems capacity Indicator 8, Form 17).

Data Capacity. The Illinois MCH program has extensive capacity to analyze data from vital records, program records, Medicaid and special surveys. The Illinois Department of Public Health produces matched birth and death certificate files, although production is behind schedule due to staff shortages. The MCH program annually produces a file of matched vital records, Medicaid eligibility, paid claims and MCH program participation that allows comparison of natality characteristics among infants that were and were not covered by Medicaid or involved in any of several MCH programs. The MCH programs primary information system, Cornerstone, includes immunization records from Medicaid-eligible children and paid claims for EPSDT services. Cornerstone is used to operate the WIC program and data from it is provided to the U.S. Centers for Disease Control and Prevention (CDC) annually for the Pregnancy and Pediatric Nutrition Surveillance Systems. The Illinois Department of Public Health maintains a complete database on hospital discharges, maintains birth defects registry and conducts the Pregnancy Risk Assessment and Monitoring System (PRAMS), the Youth Tobacco Survey, and the Behavioral Risk Factor Surveillance (BRFSS) surveys for CDC.

There are two deficiencies in Illinois' MCH data capacity. The Illinois Department of Public Health is responsible for both the Newborn Metabolic Screening program and the Vital Records System but has not linked the two data systems. Several proposals have been advanced but none have been implemented. IDHS, under contract from ISBE, assumed responsibility for contracting this year's Youth Risk Behavior Survey, but the sample was not large enough to allow for generalization.

# IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

## A. BACKGROUND AND OVERVIEW

The Illinois Title V program uses a performance management model to guide its program efforts. After choosing a set of priority needs from the five-year statewide needs assessment, resources are allocated and programs are designed and implemented to address these priorities. These program activities are described and categorized by the four levels of the MCH pyramid: direct health care; enabling; population-based; and infrastructure building services. Imbedded within the levels of service are sets of national core performance measures and ten state-negotiated performance measures categorized into three types: capacity, process, or risk factor. Because of the flexibility inherent in the Block Grant, the program activities or the role that Title V plays in the implementation of each performance measure varies. The program activities, as measured by these core and negotiated performance measures, are expected to have a collective contributory effect that will positively impact the national outcome measures for the Title V program.

## B. STATE PRIORITIES

The role of the Title V program in Illinois is to develop an appropriate infrastructure and to enable women and children to access the preventive, primary, and specialty services they require. To fulfill this role, the Title V program considers health status, demographic, health care financing, and legislative factors when setting priorities and developing new initiatives. The current priorities and corresponding initiatives of the
Title V program include:

Maternal and Infant Health

1. Reduce racial disparities in infant mortality

The reduction of infant mortality has been a priority for Illinois' Title V program for many years. While Illinois' infant mortality rate is steadily improving, it still lags behind the nation and the racial disparity between African-American and Caucasian infant mortality rates remains greater than 2:1. The expert panel on maternal and infant health convened for the needs assessment recommended as its top priority that the Title V program focus on reducing racial disparities in infant mortality.

The IDHS and the IDPH will address this objective through statewide initiatives (WIC, Family Case Management and the regionalized perinatal care program) as well as targeted initiatives for high risk populations (Targeted Intensive Prenatal Case Management, the Chicago Healthy Start Initiative, the Illinois Healthy Start Programs Partnership and Closing the Gap). The MCH program will also work closely with the IDHFS to fully implement the recommendations of the Perinatal Task Force for expansion of optional Medicaid services for the reduction of infant mortality and the improvement of perinatal health.

Progress will be monitored and reported in the Block Grant application and annual report through National Outcome Measure 2.

2. Reduce the rate of unintended pregnancy

This priority was identified through the needs assessment completed for the FFY'06 application, particularly among Medicaid-eligible women. In 2002, 43 percent of women who responded to Illinois' PRAMS survey indicated that their most recent pregnancy was mistimed or unwanted. The rate is as great as two thirds among low-income women.

This objective will be addressed through the provision of family planning services through the Title X and School-Based Health Center programs, through the Abstinence Education and Teen Pregnancy Prevention Programs (both Primary and Subsequent) and through interconceptional care provided by

the Family Case Management program and Chicago Healthy Start Initiative. The IDHS will continue to work closely with DHFS to coordinate the Family Planning program with Illinois Healthy Women (the Medicaid family planning demonstration waiver).

Annual performance will be measured through Illinois' PRAMS survey and reported in the Block Grant application and annual report through State Performance Measure 14.

3. Reduce the incidence of sexually transmitted infections, including HIV

This priority was selected because of the high rates and racial and ethnic disparities in sexually-transmitted infections in Illinois, including gonorrhea, Chlamydia and Human Immunodeficiency Virus, identified through the FFY'06 needs assessment.

The objective will be addressed primarily through the Family Planning and School Based Health Center programs. The IDHS Family Planning program has been an active participant in the Region V Infertility Project and the Illinois Infertility Project for many years. Both of these projects focus on the prevention of infertility through improved screening for Chlamydia through family planning and other sexually transmitted infection clinics. The IDHS and IDPH work together on both of these projects. The MCH program will also strengthen its collaboration with the IDPH AIDS Activity Section.

Annual performance will be reported in the Block Grant application and annual report through State Performance Measure 15. Chlamydia was selected for the performance measure because its incidence is increasing among adolescents and young adults.

Child and Adolescent Health

1. Reduce adolescent risk-taking behavior and racial and ethnic disparities in teen births

This priority was selected because of the high rates of adolescent risk-taking behavior (use of alcohol, marijuana and sexual activity) and the changing patterns of childbearing among racial and ethnic sub-groups of teens. The reduction of teen pregnancy has been a priority of the Title V program for many years, and the state's overall teen fertility rate and the proportion of all infants born to teen mothers continue to decline. However, the number of births to teens of Hispanic or Latino origin is increasing.

This priority will be addressed through the Teen Pregnancy Prevention programs (both Primary and Subsequent), the family support programs (Healthy Families Illinois, Parents Too Soon and Teen Parent Services), the Family Planning program, the Abstinence-Only Education program and the School-Based Health Centers. The MCH program will also develop new partnerships with the community-based substance abuse prevention and
youth development programs overseen by the Division of Community Health and Prevention's Office of Prevention.

Annual performance will be reported in the Block Grant application and annual report through National Performance Measure 8.

2. Promote healthy growth and development of children

This priority was selected because of the increasing prevalence of childhood overweight in Illinois, as described in the FFY'06 needs assessment.

This priority will be addressed by the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and by the School Based Health Centers. WIC's strategies to promote health growth and development are well known. The School Based Health Centers will be implementing a Continuous Quality Improvement process that will include health assessments of enrolled students and the development of interventions to improve the health of the student body. All of the health centers supported by IDHS will be addressing childhood overweight through this process.

Annual performance will be reported in the Block Grant application and annual report through National Performance Measure 11 and State Performance Measure 16.

3. Improve access to preventive and primary health care services

This priority was selected on the recommendation of the expert panel on child and adolescent health convened for the FFY'06 needs assessment.

This priority will be addressed through the Family Case Management, WIC and Family Planning programs, the School Based Health Centers and the "Mini Block Grant" to the Chicago Department of Public Health. IDHS initiated two successful campaigns to improve the number of children in the WIC program who have health insurance and to improve the proportion of infants and children in Family Case Management and WIC who are fully immunized. Due in part to the success of the Family Case Management program, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) participation rate among infants exceeds 90 percent. The IDHS will also continue to work closely with the IDHFS.

Annual performance will be reported in the MCH Block Grant application and annual report through National Performance Measures 13 and 14.

4. Improve access to mental health services

This priority was selected on the recommendation of the expert panel on child and adolescent health convened for the FFY'06 needs assessment.

This priority will be addressed through the Family Case Management, WIC, Teen Parent Services, Healthy Families Illinois, Parents Too Soon programs, the AOK Networks, and the School-Based Health Centers. Local providers of these services have been trained to conduct developmental screening through the State Early Childhood Comprehensive Systems initiative and the performance of developmental screening is monitored each quarter. Children who appear to have a developmental delay are referred to the Part C Early Intervention program for further assessment. The All Our Kids Early Childhood Networks work closely with community agencies to improve developmental screening and to improve the transition from Part C to Part B services under the Individuals with Disabilities Education Act. IDHS' Part C program and Child Care Program are both implementing mental health consultation for local service providers. The School-Based Health Centers are an important source of mental health counseling for the student bodies they serve. The IDHS is an active participant in IDPH's Suicide Prevention Task Force. The MCH program is an active participant in the Illinois Children's Mental Health Partnership. The MCH program and the IDHS Division of Mental Health have an ad-hoc working group on early childhood mental health and will pursue collaborative relationships with the Division of Mental Health to improve access to mental health services for school-aged children and adolescents.

Annual performance will be reported through the Block Grant application and annual report through National Performance Measure 16 and State Performance Measure 17.

Children with Special Health Care Needs

1. Improve access for CSHCN to quality healthcare through Medical Homes.

This issue was identified by the CSHCN Advisory Panel and by families in both the national and the DSCC Family Surveys. This is also an area of special emphasis in the Healthy People 2010 goals for CSHCN.

2. Improve access for YSCHN to transition services.

The complexity of transition issues for YSHCN was identified by the DSCC Family Surveys, (past and most recent), by respondents to the National Survey and by the CSHCN Advisory Panel as particularly problematic for youth as they leave the services and supports provided to children. DSCC identified this need in previous needs assessments and has increased efforts over time. There is still considerable effort needed in reaching more youth and their families, as well as other agencies involved in transition planning. This also is a Healthy People 2010 goal for CSHCN and a prior and continuing State Performance Measure.

3. Improve linkages to needed services for CSHCN eligible for SSI.

The CSHCN Advisory Panel identified service linkage and coordination as an overarching concern. The DSCC Family Survey (past and most recent) demonstrated that families having children receiving SSI have significant problems in accessing needed services. DSCC is more effective in addressing these issues for families with children who are also enrolled in the DSCC program. DSCC continues to reach out to families whose children are not DSCC eligible to assist them in linking to appropriate programs and services in their local communities.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 99 | 99 | 99 | 98 | 99.5 |
| Annual Indicator | 96.8 | 94.8 | 99.4 | 99.5 | 99.9 |
| Numerator | 180737 | 176079 | 181112 | 182979 | 177360 |
| Denominator | 186722 | 185749 | 182205 | 183899 | 177603 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 99.9 | 99.9 | 99.9 | 99.9 | 99.9 |

**Notes - 2002**

The 2002 denominator is provisional (preliminary CY02 number of occurrent births). Source: Illinois Department of Public Health's laboratory billing report for CY02. The 2001 numerator is the reported number of newborns screened in 2001; the 2001 denominator is the final number of occurrent births in 2001.

**Notes - 2003**

Preliminary estimates reported last year in Form 6 reported that there were 179,050 newborns screened and preliminary occurrent births were 180,000. The percentage of 99.5 percent has been extrapolated to the final 2003 number of occurrent births.

**Notes - 2004**

The denominator is provisional (preliminary number of occurrent births, Illinois Department of Public Health). The numerator is the number of newborns screened as reported by the Illinois Department of Public Health's laboratory billing report. Each year the prior year's denominator is revised when the final number of occurrent births is available from the Illinois Department of Public Health.

## a. Last Year's Accomplishments

More than 99 percent of the children born in Illinois were screened for over 30 metabolic disorders. Actual performance (99.9 percent) was above the goal of 99.0 percent.

Each year, IDPH screens more than 175,000 newborns for over 30 conditions (PKU, congenital hypothyroidism, galactosemia, congenital adrenal hyperplasia, biotinidase deficiency, hemoglobinopathies, amino acid, organic acid, and fatty acid oxidation disorders). Of these, more than 260 are diagnosed with one of these conditions, and another 4,100 are found to have an abnormal hemoglobin trait (refer to Form 6 in Appendix B). Staff assure that each infant receives appropriate referral, diagnosis, treatment, counseling and long term follow-up services.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Newborns are routinely screened for more than 30 metabolic disorders. Infants with a positive screening result are followed through diagnostic evaluation, and children diagnosed for some conditions are followed up through 15 years of age.

## c. Plan for the Coming Year

The IDPH Genetics/Newborn Screening program will establish practices to ensure that every newborn in the state is screened. IDPH and DSCC will continue to partner in the care of children diagnosed with a metabolic or genetic disorder. A request for proposals is being issued for a web based Newborn Metabolic Screening Data System that will interface with the birth record to ensure that all Illinois infants are screened.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18*

*years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 60.6 | 60.6 |
| Annual Indicator | | | 60.6 | 60.6 | 60.6 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 60.6 | 60.6 | 60.8 | 60.8 | 60.8 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

## a. Last Year's Accomplishments

The 2003 National Survey on Children with Special Health Care Needs (CSHCN) Survey indicated that 60.6 percent of Illinois families with CSHCN ages 0 to 18 reported partnering in decision making at all levels and were satisfied with the services they receive.

DSCC continued existing initiatives to build and strengthen family and professional partnerships. The Family Advisory Council (FAC) assisted with revisions to the DSCC Coordinated Care Record and updated the DSCC Family Handbook to include information on the Medical Home, Transition, Individualized Family Service Plans and family rights under the Health Insurance Portability and Accountability Act (HIPAA). DSCC attempted to provide family support groups, although the response was minimal. Families were invited to multidisciplinary conferences on the Medical Home in December 2003 and April 2004.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. | | | | |
| 2. | | | | |

| | | | | |
|---|---|---|---|---|
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

DSCC is supporting and, when feasible, building on its existing initiatives to encourage a system of care that promotes family and professional partnerships through education, family-to-family networking, and implementation of the Medical Home. DSCC is maintaining its education and awareness activities for families of
CSHCN, disseminating a family newsletter, Special Addition (including a Spanish version), with articles on family decision-making and leadership. Current initiatives and resources are being updated on the DSCC website. DSCC continues to support the FAC and to explore other strategies to support families. DSCC supported ten youth and their families to attend the statewide transition conference.

c. Plan for the Coming Year

DSCC will continue to support family participation in DSCC staff conferences by planning a family track with skill building sessions on advocacy for the November 2005 conference. Families attending the Institute for Parents of Preschool Children who are Deaf or Hard of Hearing will again be offered a limited scholarship to enable their attendance at the weeklong program. The Family Page on the DSCC website and the Special Addition will continue to be used to keep families informed of MCHB and DSCC initiatives and other resources. The FAC will continue to explore additional strategies that DSCC could utilize for supporting families as partners in decision-making.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 50.7 | 50.7 |
| Annual Indicator | | | 50.7 | 50.7 | 50.7 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or | | | | Final | Final |

| | | | | | |
|---|---|---|---|---|---|
| Final? | | | | | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 50.7 | 50.7 | 50.9 | 50.9 | 50.9 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

## a. Last Year's Accomplishments

The 2003 CSHCN Survey found that 50.7 percent of Illinois families with CSHCN reported that they received coordinated, ongoing comprehensive care within a Medical Home.

DSCC continued efforts to increase awareness about the Medical Home Model by providing presentations at conferences and to physician practices and in conjunction with developmental screening trainings. Presentations were made to four physician practices, Lutheran General Hospital in Chicago, the University of Wisconsin in Madison, MCH staff of the U.S. Virgin Islands, and families and physicians at the Critical Partners Conference in Orlando, CoACH Care Coordination conference in Downers Grove, IL, and the Family Support America conference in Chicago. Additionally, Dr. Onufer provided trainings to primary care physicians in southern Illinois on the importance of developmental screening and standardized tools appropriate for use in pediatric and family physicians' offices. Developmental screening kits were purchased for distribution to physicians participating in the developmental screening trainings and becoming Medical Home providers enrolled in DSCC.

Two Medical Home conferences were planned for downstate Illinois targeted to families and physicians, but both were cancelled when registrations were too small to justify the effort. Medical Home Primers for physicians and for families were revised and added to the DSCC website.

DSCC initiated Medical Home Quality Improvement Teams (QITs) in four physician practices in Illinois. One team's physician is in a rural community in northern Illinois, two teams are in physician practices in the Chicago suburbs, and the fourth team is associated with a pediatric residency program in central Illinois. Each QIT has a physician, two parents with children served by the practice, a staff member that provides some level of care coordination in the practice, and a facilitator provided by DSCC. The teams meet on average once a month and follow the process outlined in the Medical Home Improvement Kit developed by the Center for Medical Home Improvement to make changes in their respective practices. Each QIT has completed a Medical Home Index and the families have completed the Medical Home Family Index.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
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## b. Current Activities

DSCC successfully held a Medical Home conference at the Shriners Hospitals for Children in Chicago in November 2004. Presentations have also been provided at the National Medical Home conference in Chicago in July 2004 and the Head Start Association conferences in Mt. Vernon, IL, in October 2004 and in Springfield, IL, in March 2005.

DSCC is collaborating with the Illinois Chapter of the American Academy of Pediatrics (ICAAP) to provide training and facilitation to six Medical Home QITs, mainly in northern Illinois during the first phase of the grant (July 2004 through June 2006). This effort is funded through a multi-year grant to ICAAP that will increase the number of QITs in future years. In Phase II (July 2006 through June 2008), additional demonstration practices and three control practices will be added. Developmental screening kits have been distributed to the participating practices. DSCC also collaborated with the Illinois Head Start Association and a community pediatrician to obtain a CATCH Planning Grant to improve access to quality health care using the Medical Home Model for children without a primary care physician. Family focus groups have been conducted at two rural Head Start sites, Rock Falls and Batavia; at two suburban sites, East St. Louis and Danville; and at two urban sites in the city of Chicago, one of which serves Hispanic families. Additionally, physician focus groups are planned for those same communities during the summer of 2005. The purpose of the focus groups is to gain better understanding of the issues for Head Start families who do not have a primary care physician from the perspectives of the families and the physicians and to identify potential strategies to address those issues. This collaborative effort will provide a model that can be implemented statewide to improve families' abilities to access primary care providers with the assistance of their Head Start Coordinator.

DSCC and two Illinois pediatric practices have been accepted for the National Institute for Child Health Quality (NICHQ) Medical Home Learning Collaborative II and attended the first two learning sessions in March and June 2005. Additionally, DSCC is collaborating with The Hope School in Springfield, IL on their Medical Home grant that will focus on Medical Homes for children with autism and developmental disabilities. DSCC's Director and Family Liaison presented information on the Medical Home Model and parent partnerships in March 2005 for Hope School families and community physicians.

DSCC care coordinators continue to approach primary care providers identified by families in the DSCC programs to become enrolled as Medical Home providers. Enrolled Medical Home providers can bill DSCC for care coordination and telephone consultation services.

## c. Plan for the Coming Year

DSCC plans to continue supporting ongoing activities that promote Medical Homes for CSHCN in Illinois through the collaborative grant activities already in place and through Block Grant support for QITs in physician practices. DSCC is involved with seven grant activities promoting

the Medical Home Model:

ICAAP MCHB Grant for implementing a Medical Home quality improvement process in six demonstration practices for the first two years and another nine practices for the second two-year period.

Illinois Head Start Association CATCH Planning Grant for improving access to a Medical Home for the 11 percent of children in Head Start without a primary care physician.

NICHQ Learning Collaborative II for facilitating a quality improvement process in two practices.

Chicago Epilepsy Foundation grant for improving access to a Medical Home for children with epilepsy.

The Hope School grant from the Illinois Child Health Foundation for developing a Medical Home model for developmental screening and early detection of autism spectrum disorders.

An American Legion grant to develop the Illinois Medical Home Care Coordination Organizer.

Region IV HRSA Genetic Collaborative Grant to develop a "Medical Homes In Action" website related to newborn metabolic screening. This website will provide information for both families and physicians about inheritable disorders.

DSCC central office staff will provide the facilitation needed for QITs, and regional office staff will continue to discuss the Medical Home concept with families, pediatricians and family physicians in their communities.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 53.3 | 53.3 |
| Annual Indicator | | | 53.3 | 53.3 | 53.3 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 53.3 | 53.3 | 53.5 | 53.5 | 53.5 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

## a. Last Year's Accomplishments

The 2003 CSHCN Survey found that 53.3 percent of Illinois families with CSHCN reported that they had adequate private and/or public insurance to pay for the services they need.

Despite declining revenues, DSCC has successfully maintained service levels through more efficient utilization of public and private insurance. DSCC's benefits management technical support team, staffed by specialists trained in insurance utilization, provided training to 21 new care coordination staff members and made 73 technical assistance visits. The team provided technical support, educating staff on medical benefit plans and effective strategies to coordinate public and private funding sources. Also, this team posts and maintains a web based resource page for key benefit management data and information and provides related links to enhance benefits management activities for care coordination staff. The DSCC Family handbook included information on how DSCC can assist families in coordination of public and private funding sources for needed health care. Acting as KidCare Application Agents, DSCC staff assisted families who were potentially eligible for the KidCare Program to apply. Benefits management staff also participated in the Early Intervention Insurance workgroup recommending an overall framework for use of private health insurance.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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## b. Current Activities

DSCC care coordination staff continues to assist families who appear to be potentially eligible to apply for the KidCare Program. DSCC staff participates in statewide Covering Kids and Families Illinois meetings that are sponsored by the Illinois Maternal and Child Health Coalition, the Illinois Department of Public Aid and the Illinois Department of Human Services. DSCC provides the following brochures for families in print and on its website: Choosing and Getting the Most from Your Managed Care Plan, Insurance Terminology for Families, DSCC and

KidCare and Understanding Health Insurance on its website. The benefits management technical support unit is identifying liaison contacts with key public and private organizations. Collaborative efforts continue with the Illinois Comprehensive Health Insurance Plan, IDPA, and IDHS to maintain and promote awareness of eligibility guidelines, program services and enrollment procedures. To assist care coordinators, DSCC has developed a method to track online those services that private and public health insurance programs exclude from their benefits package.

### c. Plan for the Coming Year

The benefits management technical support unit in collaboration with the FAC, Family Liaison Specialist and other interested family advocacy groups is developing a training module for families on accessing third party payers, including negotiating benefits and appealing decisions. In addition, a benefit management guide will be developed to provide additional tools for DSCC staff and families. Topics will include a definition of benefits management, the process of implementing effective benefit management strategies, types of public/private plans, selecting an insurance plan, how to access public/private program benefits, continuation of coverage and creditable coverage guides, glossary of terms and a resource address book. DSCC will continue participation in Covering Kids and Families Illinois meetings, maintain liaison contacts with public/private organizations and share program benefit information with key state agencies. DSCC will continue to refer uninsured applicants and recipients to the state KidCare Program. Currently, 94 percent of DSCC children have a primary source of health benefits. DSCC administration plans to assess uninsured families to evaluate strategies to assist those families to secure third party benefits. Additional online tools will be developed to expand benefit management capacity to maximize all third party payers.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 76.1 | 76.1 |
| Annual Indicator | | | 76.1 | 76.1 | 76.1 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 76.1 | 76.1 | 76.3 | 76.3 | 76.3 |

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

## a. Last Year's Accomplishments

The 2003 CSHCN Survey found that 76.1 percent of Illinois families with CSHCN reported that the community-based services systems were organized so that they can use them easily.

DSCC addressed system organization through coordination with an array of state agencies that provide services to children such as early intervention, transition, foster care and KidCare. DSCC maintains Memoranda of Understanding (MOU) as described in Section III, State Overview, State Agency Coordination. MOUs provided a state level framework for interagency cooperation and coordination, allowing DSCC to facilitate activities such as: Otologic/Audiologic clinics, Preschool Deaf Institute and follow?up diagnostics for infants who need evaluation as a result of the state's Newborn Hearing Screening or the Newborn Metabolic Screening Programs. For those families eligible, DSCC provides a regional care coordination structure to assist families in navigating community?based systems through development of an Individualized Service Plan (ISP). Care coordinators also provided regional and local outreach to other providers and agencies such as the Local Interagency Councils for Early Intervention and Transition. DSCC provided information and referral services, including telephone contact, to families of those children newly eligible for SSI 16 years of age or less, referring 235 children to the Early Intervention Program.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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## b. Current Activities

DSCC continues to collaborate with other health, social service, and education entities at state and local levels. Many of the state level coordination activities are addressed in section III E. The Interagency Agreement with the Illinois Department of Healthcare and Family Services (IDHFS) was updated, and a three agency agreement among DSCC, IDHFS, and IDHS' Divisions of Rehabilitation Services and Developmental Disabilities was drafted to support and guide transition efforts for children moving from the Medicaid waiver operated by DSCC to the

Medicaid waivers operated by IDHS. DSCC regional office care coordinators participate in various interagency efforts in the communities they serve.

DSCC continues to mail information in English and Spanish, providing referral services to families of children age 16 years or less that are newly eligible for SSI. DSCC staff telephoned 580 families and referred 180 to needed programs and services.

### c. Plan for the Coming Year

DSCC will continue to coordinate and collaborate with state agencies and local groups to identify and resolve service gaps and duplication. Community system development efforts will be continued in all areas of the CSHCN Healthy People 2010 goals with emphasis on Medical Home, Transition and Early Intervention. Significant effort will be made in the area of newborn hearing screening as discussed in Federal Performance Measure # 12. Efforts to assist families of children eligible for SSI in accessing necessary services will continue.

## Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | 5.8 | 5.8 |
| Annual Indicator | | | 5.8 | 5.8 | 5.8 |
| Numerator | | | | | |
| Denominator | | | | | |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 5.8 | 5.8 | 5.9 | 5.9 | 5.9 |

**Notes - 2002**

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

**Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

### a. Last Year's Accomplishments

The 2003 CSHCN Survey found that 5.8 percent of Illinois youth and their families received the services necessary to make transition to all aspects of adult life.

DSCC's continued collaborative efforts through the Illinois Interagency Coordinating Council (ICC) Staff represented DSCC on the Training and Technical Assistance subcommittee that developed an ICC Compendium of Programs and Services and an ICC interagency training session that was provided in May 2004. Staff also represented DSCC on the Public Outreach subcommittee to develop the ICC website. DSCC's commitment to the Transition Outreach Training for Adult Living (TOTAL) project through the Illinois State Board of Education completed its third year with the development of a health care media module. Health care transition presentations were developed and incorporated into the DSCC Medical Home Conference efforts. Staff co-presented with the staff from the Rehabilitation Institute of Chicago (RIC) to Chicago Public School's occupational and physical therapists in anticipation of developing a transition clinic at RIC. DSCC provided two-day trainings to MCH staff and other community stakeholders in the U.S. Virgin Islands. A presentation was also given at the MCHB Annual Health Leadership Conference about DSCC health care transition efforts and evaluation. Participation in the Regional Transition Planning Consortiums (TPCs) allowed opportunities for staff to present to families, youth, and professionals on health care transition and the importance of addressing all of the aspects of the youth.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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## b. Current Activities

Stronger, continued efforts through the ICC are leading toward change among systems. Through the ICC Public Outreach subcommittee, initial efforts are occurring to establish baseline standards of documentation for reasonable accommodations across the postsecondary settings in Illinois. This effort is in collaboration with secondary personnel, representatives from the Illinois Higher Board of Education, Illinois Community College Board, DHS Division of Rehabilitation Services, and DSCC. Various health care presentations have occurred in areas for youth, allied health professionals, rehabilitation personnel, educators, and other agency representatives. Technical assistance was provided for the Michigan Title V transition personnel, and ongoing technical assistance is provided through DSCC Regional Office visits and to medical facilities, such as the Schwab Rehabilitation Center and RIC. DSCC staff are members of the steering committee and subcommittees for a statewide transition conference "Today's Student, Tomorrow's Adult." Presentations are targeted to youth, families, and professionals for the purpose of giving them transition information in all aspects of adult

life. DSCC staff are also presenting on health care transition for the youth track.

### c. Plan for the Coming Year

Ongoing outreach activities and presentations, as well as collaborative efforts with other agencies and projects will continue. Efforts to strengthen relationships with health care professionals and train them on the importance of including youth in their health care will be a major focus. ICC efforts to develop collaborative system change will continue. The ICC Outreach subcommittee plans to continue working to create statewide standards for documentation needed for youth to gain reasonable accommodations in all Illinois postsecondary settings. The DSCC Transition and Medical Home teams are pursuing the Champions for Progress Initiative Grant from the Early Intervention Research Institute of Utah State University to offer informational sessions on transition issues/resources to pediatrician practices.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 76 | 79 | 78 | 79 | 82 |
| Annual Indicator | 75.4 | 75.6 | 79.6 | 84.6 | 84.3 |
| Numerator | 209628 | 209793 | 205864 | 216602 | |
| Denominator | 278021 | 277504 | 258623 | 256031 | |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 84.5 | 85 | 85.5 | 86 | 86.5 |

**Notes - 2002**

Illinois has revised statistics from 1998 to 2002 to reflect data of vaccination coverage with 4:3:1:3. Source: Annual Q1/Q4 US National Immmunization Survey, Estimated Vaccination Coverage with 4:3:1:3. The most recent data available for 2002 is period Q3/2001-Q2/2002 and is marked provisional on this form.

**Notes - 2003**

Source: Estimated Vaccination Coverage with 4:3:1:3 Among Children 19-35 Months of Age by Race/Ethnicity -- National Immunization Survey. Final data are for children in the Q1/2003-Q4/2003 National Immunization Survey who were born between February 2000 and May 2002.

**Notes - 2004**

Estimated Vaccination Coverage with 4:3:1:3 Among Children 19-35 Months of Age by Race/Ethnicity -- National Immunization Survey. Final data for a given year includes Q1-Q4; the most current 2004 data available are provisional, Q3/2003-Q2/2004. This report does not provide a numerator or denominator.

The Chicago project area received an award at the 39th annual WIC conference for the highest improvement in a metropolitan/urban area.

## a. Last Year's Accomplishments

Illinois achieved its goal of ensuring that 82 percent of two-year-olds were fully immunized. Actual performance in 2004 was 84.3 percent, according to National Immunization Survey (NIS) results.

IDHS, IDPH, and IDHFS are collaborating on a campaign to improve the immunization level of children participating in the WIC program. Local WIC agencies (most of which are local health departments) receive regular reports from the IDHS on the proportion of infants and toddlers in the WIC program who are fully immunized. During FFY'04 the proportion of fully immunized one-year-olds increased by 2.4 percent (from 84 to 86 percent) and the proportion of fully immunized two-year-olds also increased by 6 percent (from 71.2 to 75.4 percent).

IDHS is using the Cornerstone system to establish an immunization registry. Local health departments enter data on immunizations provided through their clinics. Data on immunizations provided to Medicaid-eligible infants and toddlers by private-sector physicians are added from IDHFS's Medicaid Management Information System on a monthly basis. Further, the Department has worked with the Chicago Department of Public Health, the Cook County Health Department and their software vendor to import immunization records from their data systems. Finally, Cornerstone is linked to IDPH's "Tracking Our Toddlers Shots," or "TOTS" software. IDPH provides TOTS software to interested physicians for use in their practices.

Through HealthWorks of Illinois, Immunization rates for all DCFS wards birth through five years of age increased to 70 percent in Cook County and 93 percent downstate as of March 2004. These rates were 48 percent and 58 percent, respectively, as of September 30, 1998.

IDPH provides federal immunization grant funds to support Vaccines for Children Assessment, Feedback, Incentives and Exchanges (VFC-AFIX) and provider education initiatives through the Illinois Chapter of the American Academy of Pediatrics (ICAAP), Rockford Health Council, CCDPH, and Will County Health Department.

Chicago. The Chicago Department of Public Health used Outreach funds from CDC to support its Keeping Immunizations Current for Kids (KICK) initiative that includes the University of Illinois at Chicago Pediatric Immunization Program (PIP), to expand the community Outreach and Residential Education Program, support community and private provider education programs with the Chicago Area Immunization Campaign, and to enhance WIC clinic interventions. A focus has also been placed upon the St. Bernard's Hospital Baby Immunization Tracking System (BITS) program to improve coverage in the Englewood Community Area. Outreach funds were also awarded to Sinai Community Institute and Lawndale Christian Health Center to address "grass roots" efforts in the North Lawndale community.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
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| | DHC | ES | PBS | IB |
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## b. Current Activities

The Office of Family Health continues to provide regular reports on the number and proportion of fully immunized one and two-year-olds to WIC providers across the state.

The IDPH Immunization program is federally-funded and is authorized by Section 317 of the Public Health Service Act. Additional federal funds are awarded annually through the federal Vaccines for Children (VFC) program which routinely:

Promotes the use of vaccines to prevent the occurrence and transmission of diseases;
Distributes vaccines to public and private providers statewide through the Vaccines for Children Plus program;
Conducts surveillance and investigates outbreaks of preventable childhood and adult diseases;
Interprets and educates providers, day care centers, schools, and colleges on immunization requirements;
Maintains the Tracking Our Toddlers Shots (TOTS) immunization registry and develops web-based registry applications Illinois Comprehensive Automated Registry Exchange (I-CARE);
Provides education and training to public and private vaccine providers, day care centers, schools, colleges, hospitals, and the general public through partnerships with public campaigns, community coalitions (i.e., Chicago area Immunization Campaign, Rockford Health Council), volunteer groups, vaccine manufacturers, professional organizations and federal agencies;
Conducts mandatory assessments of vaccine coverage levels among various target populations, including VFC enrolled providers, and public clinics;
Works with the IDHFS to improve immunization levels among Medicaid-eligible children, as required for the Government Performance and Results Act; and
Implements other initiatives to accomplish the immunization objectives in Healthy People 2010.

During FY'05, IDPH maintained VFC-AFIX efforts in several "Pockets of Need." These activities were conducted by local health departments and community organizations.

## c. Plan for the Coming Year

IDHS, IDPH, and IDHFS will continue the WIC Immunization campaign. Immunization records will be added regularly to the Cornerstone and TOTS Systems from the Medicaid Management Information System and the immunization tracking software used by the Chicago and Cook County health departments.

Quarterly reports on the immunization coverage of one and two-year-olds will be provided to local WIC agencies. The information will be followed up with consultation and technical assistance from regional staff.

IDPH will continue the following assessment activities:

Conduct and review the annual DCFS/IDPH child care and Head Start survey. The survey will be distributed to approximately 2,200 child care and Head Start centers in Illinois (excluding Chicago). (A separate survey is conducted by the Chicago Department of Public Health. Results are provided to IDPH.) The program will also work with the Child Care Resource and Referral Networks to educate child care facility staff regarding implementation and enforcement of immunization requirements. The survey has been revised to aid completion, improve compliance and meet CDC reporting needs.

IDPH will conduct a minimum of 437 VFC-AFIX visits to private providers within VFC to determine VFC compliance and conduct assessment of practice coverage levels.

The annual quality assurance reviews to determine compliance with the Standards for Pediatric Immunization Practices will continue. The reviews have proven to be successful in identifying existing barriers and documenting recommendations for improvements in clinic practices. Documentation required to comply with the National Childhood Vaccine Injury Act is reviewed thoroughly. Quality assurance reviews will use the AFIX strategy as developed by CDC.

IDPH has a grant agreement with the Illinois Chapter of the American Academy of Pediatrics to extend AFIX services and conduct peer provider education according to a curriculum developed entitled, "Reaching Our Goals." This peer education strategy will also promote "birthdose" Hepatitis B vaccine efforts. A grant agreement with Rockford Health Council will be maintained to address AFIX and provider education in Winnebago, Boone, and Ogle Counties. AFIX agreements were added in Peoria, Macon, and Madison Counties.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 30 | 29 | 26 | 23.5 | 23 |
| Annual Indicator | 28.5 | 26.2 | 23.5 | 22.9 | |
| Numerator | 7156 | 6635 | 6090 | 5922 | |
| Denominator | 251088 | 252949 | 259596 | 258991 | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 22 | 21 | 21 | 20 | 20 |

**Notes - 2002**

Teen births are vital records data. Illinois vital records data for 2002 were not available during

the preparation of this application. The 2002 percent shown is an estimate based on the 2001 performance and the decline rate of teen births.

**Notes - 2003**

Teen births are vital records data. Sources: 2003 Birth File, Center for Health Statistics, IDPH and the 2003 Bridged-Race estimate for Illinois, provided by IDHS.

**Notes - 2004**

Vital records data were not available at the time this application was being prepared. The 2004 Annual Performance Objective will be changed to a rate of 22 per 1,000 teens.

## a. Last Year's Accomplishments

Illinois exceeded its objective of 23.5 births per 1,000 15 to 17- year-old women in 2003; actual performance was 22.9 per 1,000. The birth rate among 15 to 17-year-olds has declined by 23 percent between 1999 and 2003. (These are the most recent data available.)

The number and percent of births to teen mothers fell to a new record low in 2003. Several programs in the Office of Family Health contributed to this achievement:

Abstinence-Only Education, which provided abstinence-until-marriage instruction to 73,900 children and adolescents in SFY'04;
The Primary and Subsequent Teen Pregnancy Prevention programs provided services to 120,059 adolescents in SFY'04;
Teen Parent Services, which helped more than 3,560 low-income teen parents work on finishing school and move from welfare to work in SFY'04;
Parents Too Soon, which, in SFY'04, helped more 3,560 teen parents develop parenting skills, delay a subsequent pregnancy and finish school; and
The Family Planning program, which provided comprehensive reproductive health services to 42,186 adolescents in CY'04.

This comprehensive array of services includes widely recognized best practices for helping teens make healthy choices.

Chicago. Using the census data for 2000, the 2003 birth rate for teens aged 15 through 17 years of age was calculated at 43.6/1,000. This was a significant (17.1 percent) decrease from the 49.3/1,000 noted in 2001. Between 2002 and 2003, the birth rate by race and ethnicity for teens aged 15-17 years continued to decline for all groups. The rate for Non-Hispanic Blacks declined from 58.1/1,000 in 2002 to 55.6/1,000 in 2003; for Non-Hispanic Whites 8.7/1,000 in 2002 to 7.4/1,000 in 2003; and for Hispanics from 52.6/1,000 in 2002 to 45.6/1,000 in 2003. Through its case management, public health nursing, outreach, family planning, and male responsibility programs, the CDPH will continue to assure that services are provided so that repeat pregnancies are
prevented. The Male Involvement and Family Planning programs provide education to teens on abstinence and the prevention of sexual coercion.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
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b. Current Activities

Primary and Secondary Prevention of teen pregnancy and sexual activity before marriage is being addressed by the routine activities of the Abstinence-Only Education, Parents Too Soon, Teen Parent Services, Teen Pregnancy Prevention, School-Based/School-Linked Health Centers, School Health and Family Planning programs.

Chicago. Through its case management, public health nursing, outreach, Family Planning and Male Responsibility programs, and in collaboration with the Chicago Public Schools' "Cradle to Classroom" program, the CDPH will continue to assure that services are provided so that initial and repeat pregnancies are prevented.

c. Plan for the Coming Year

Prevention of teen pregnancy and sexual activity before marriage will be addressed by the routine activities of the Abstinence-Only Education, Parents Too Soon, Teen Parent Services, Teen Pregnancy Prevention, School-Based/School-Linked Health Centers, School Health, and Family Planning programs. In preparation for SFY'06, the department has re-bid the Primary Teen Pregnancy Prevention program. This was done so that services can be directed to areas of the state with the greatest need while providing the opportunity for other local agencies to meet the needs of their communities. The Department, in collaboration with the IDHFS and the Illinois Planned Parenthood Council, will develop a plan to promote awareness of emergency contraception.

Chicago. Through its case management, public health nursing, outreach, Family Planning, Male Responsibility programs, and in collaboration with the Chicago Public Schools' "Cradle to Classroom" program, the CDPH will continue to assure that services are provided so that initial and repeat pregnancies are prevented.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 27 | 28 | 9 | 9.2 | 9.5 |
| Annual Indicator | 12.6 | 9.0 | 9.2 | 9.2 | 27.0 |
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Numerator | 20353 | 14655 | 15126 | 14842 | 42219 |
| Denominator | 161530 | 162837 | 164413 | 161329 | 156370 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 27 | 27 | 27 | 27 | 27 |

**Notes - 2002**

Data is extrapolated to the number of 3rd grade children enrolled in year 2002.

**Notes - 2003**

In lieu of reporting the number of 3rd grade children in the State, the percent is the number of Illinois children ages 7, 8 and 9 enrolled in Medicaid/Kidcare in FFY2003 who received at least one sealant was reported. (Source: Illinois Department of Public Aid, Data Warehouse).

In keeping with the detail sheet for this objective, the number of children in Grade 3 of Illinois public schools and facilities during school year 2003-04 is being substituted in FY2003. (Source: Illinois State Board of Education).

**Notes - 2004**

In keeping with the detail sheet for this objective, the number of children in Grade 3 of Illinois public schools and facilities during school year 2004-05 is being reported in FY2004. (Source: Illinois State Board of Education). IDPH estimates that 27 percent of those children are eligible to receive dental sealants through Medicaid and their Dental Sealant Program.

## a. Last Year's Accomplishments

Illinois revised its goal of increasing the proportion of third-grade children who have protective sealants on at least one permanent molar tooth. The state's actual performance was 27 percent.

In school year 2003-2004, DOH completed a basic screening survey of third grade children. The Healthy Smiles/Healthy Growth survey obtained important information about caries history (whether or not a child had evidence of any prior cavities), current unt5eated cavities, treatment urgency, presence of sealants, demographics and socioeconomic variables and taking height and weight measurements to determine BMI. DOH and Chronic Disease Prevention and Control collaborated to conduct the open mouth survey utilizing a guide from the Association of State and Territorial Dental Director's "Basic Screening Survey." The collaboration allowed BMI to be calculated by taking height and weight measurements. The Centers for Disease Control and Prevention (CDC) researchers and health professionals use BMI as the preferred method for determining overweight and obesity. Of 101 schools sampled, across the state, 99 participated in the survey, and 6,630 out of 9,000 eligible children were screened. Data was collected in such a manner to allow analysis based on urbanicity as well as representative specifically to the City of Chicago, Cook and the Collar Counties. Screener training was conducted during the fall of 2003, and data collection began in December of 2003 and ran through June of 2004. Twenty-six local agencies were trained to consistently conduct the surveys in a uniform manner.

This performance measure is addressed by the IDPH Dental Sealant Grant program. Retention rates, monthly and quarterly reports, and on-site reviews are utilized to evaluate program performance. Communities are responsible for developing protocols for their programs in order to assure proper infection control, retention rates, equipment maintenance, patient referral and follow-up, and adequate procedures for assuring eligibility.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
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| 10. | | | | |

## b. Current Activities

IDPH has 55 sealant program grantees providing preventive oral healthcare throughout the state. The City of Chicago program continues to grow and the Cook County program has suspended school-based activity in lieu of clinic-based services.

The IDHFS monitors Medicaid and SCHIP eligible children between the ages of five and fourteen who have received one to three sealants and four to eight sealants. For calendar year 2004, 9.25 percent of Medicaid-eligible children and 8.32 percent of SCHIP-eligible children had received four to eight sealants, and 3.65 percent of Medicaid-eligible children and 3.69 percent of SCHIP-eligible children had received one to three sealants.

Chicago. A Quality Assurance Program has been implemented in Chicago and 99 schools are being served. All of the oral health care providers are being reviewed to assure the quality of care. During the academic year 2002-2003, 632 second-graders received sealants, with a 95 percent retention rate; they became third-graders in 2003--2004. During the academic year 2003-2004, 723 second-grade students received sealants, with a 99 percent retention rate. These became third-graders in 2004-2005.

## c. Plan for the Coming Year

The Dental Sealant Program will be evaluated by the DOH staff. Data collection from grantees will be expanded by use of optiform scannable forms. The Division of Oral Health will continue its efforts to support and expand the DSGP program.

The IDPH Division of Oral Health is partnering with IDHS' School-Based Health Centers on a pilot project to help prevent oral diseases in Illinois children. Several centers will implement an oral health curriculum entitled, "Cavity Busters."

Chicago. The Director of the School-Based Dental Sealant Program is continuing to work with representatives from the federal and state agencies, private dentists through their associations and the Chicago Public Schools to improve preventive and curative dental services for the women and children. The goal is to increase the quantity of sealants provided to the children. During the next fiscal year, the sealant program will continue to expand services to children in

the Chicago Public Schools.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 2 | 1.9 | 2.8 | 2.7 | 2.6 |
| Annual Indicator | 3.0 | 2.9 | 2.8 | 3.0 | 2.4 |
| Numerator | 80 | 80 | 75 | 76 | 66 |
| Denominator | 2711504 | 2728100 | 2678600 | 2534267 | 2699740 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 2.4 | 2.4 | 2.3 | 2.3 | 2.3 |

**Notes - 2002**

The 2002 vital records data was not available at the time this application was being prepared.

The 95% Confidence Intervals for this rate during the last four years are as follows: 1998, 2.7 to 4.2; 1999, 2.8 to 3.2; 2000, 2.3 to 3.7; 2001, 2.3 to 3.6. Visual inspection of year to year variation in the rates suggests that changes from one year to the next are not statistically significant. These confidence intervals were calculated using the Poisson distribution.

**Notes - 2003**

The number of 2002 deaths and the rate were provided by the Illinois Department of Public Health, Center for Health Statistics and were used to extrapolate the provisional denominator (rounded up). Using the 2002 Illinois Bridged-Race Census Estimates for children less than age 14 (2,534,267) the rate is 3.0.

**Notes - 2004**

The 2003 fatal crash data as reported by the Illinois Department of Transportation are new provisional data for the numerator effective 6-2005. These data will be replaced with final numbers from IDPH as they become available. The denominator is the 2003 Bridged Race Estimate for Illinois.

a. Last Year's Accomplishments

Illinois achieved its goal of reducing the rate of motor vehicle crash deaths among children between one and 14 years of age to 2.6 per 100,000 children. Actual performance (based on provisional data) was 2.4 per 100,000.

The Department continued its partnership with the City of Chicago Police Department, the

Illinois State Police, the City of Chicago Hispanic Health Coalition, local hospitals and health centers, and the Illinois Department of Children and Family Services to conduct community child safety seat checks. Through this partnership, 15 safety seat checks were held, and 520 car safety seats were distributed to low-income families and cars were checked for proper seat installation. The Illinois State Police provided audiovisual equipment to play a videotape that portrayed the cause and effects of injuries and fatalities resulting from motor vehicle crashes. This included seat belt use, as well as proper car seat installation.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
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b. Current Activities

Due to a lack of funds, the Department has significantly reduced the distribution of car safety seats.

c. Plan for the Coming Year

The Department will expand the number of Child Safety Seat checks statewide, in conjunction with the Governor's Keep Kids Safe and Warm Campaign. The Department and the Illinois State Police, along with a network of health departments, community-based organizations, Department welfare offices, and churches will conduct child safety seat checks and distribute child safety seats in the coming year.

Healthy Child Care Illinois CCNCs provide families and child care providers with educational support and resource referrals on transportation safety to include the importance of child safety seats.

All students enrolled in SBHCs are assessed for risk of unintentional injury and provided with health education focused on injury prevention, bicycle safety and seat belt use.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| | | | | | |

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 64 | 64 | 66 | 68 | 69 |
| Annual Indicator | 64.8 | 65.2 | 68.0 | 60.7 | |
| Numerator | 119882 | 119982 | 123899 | 111627 | |
| Denominator | 185003 | 184022 | 182205 | 183899 | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 70 | 71 | 72 | 73 | 73 |

**Notes - 2003**

The Ross Survey for 2003 indicates a percentage. The numerator has been extrapolated to the total occurrent births in 2003. See the application narrative for a comparison of Ross and other survey results.

**Notes - 2004**

The Ross Survey percentage for 2004 was not available at the time this application was being prepared.

## a. Last Year's Accomplishments

Illinois did not meet its goal for increasing the proportion of mothers who were breastfeeding at hospital discharge. The state's actual performance in FY'03 was 60.7 percent, and the objective was 68 percent.

Last year 18 local agencies received funding and technical assistance to develop programs.

The rate of breastfeeding at hospital discharge has increased among WIC participants from 26 percent in 1992 to 54.1 percent in FY'04. Further, the proportion of WIC participants who continue breastfeeding for six months has increased from 11.4 percent in 1992 to 21.7 percent in FY'03. The rate of breastfeeding among WIC-eligible women has doubled since 1992.

WIC program activities to promote and support breastfeeding include:

Providing technical assistance and consultation on breastfeeding promotion, support, and management for health departments and other local agencies administering - WIC programs statewide;
Providing items for local agency use in promoting breastfeeding within their local communities, for use during World Breastfeeding Week, Illinois Breastfeeding Month, and throughout the year;
Promoting and supporting the activities of the State and Regional Breastfeeding Task Forces throughout the state, collaborating with hospitals, area community groups, and breastfeeding advocacy organizations, including support for regional Task Force Conferences and activities such as Breastfeeding Walks, Breastfeeding in the Park, Breastfeeding is an Art, and the "Mobile Nursery";
Providing training and educational opportunities for local agency's and providers' staff to

include breastfeeding in comprehensive service delivery to eligible clients, including other MCH programs;
Developing and distributing educational materials and resources for breastfeeding support and promotion with agency partners and community stakeholders;
Promoting and supporting the activities of the Physicians' Breastfeeding Network of Illinois as they promote breastfeeding education for physicians and in medical schools;
Administering a state breast pump distribution program through local agencies, including ongoing education;
Supporting the activities of local agency breastfeeding coordinators statewide through technical assistance, training, and educational materials;
Providing breastfeeding training and educational opportunities to all health department staff on a regional basis, utilizing local agency staff specially trained in lactation education to train staff in other agency programs, i.e., Family Case Management, Immunizations, TPS, HFI, and others.
Collecting data on breastfeeding practices through the Cornerstone Information System for CDC Nutrition Surveillance Systems;
Developing and implementing breastfeeding training based on documented educational needs for Family Case management, WIC and other MCH providers; and
Providing technical assistance and consultation on the development and implementation of the Loving Support Breastfeeding Peer Counselor Program in 18 agencies.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
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b. Current Activities

Illinois Breastfeeding Promotion Month will be celebrated in August, coinciding with International World Breastfeeding Week. Activities will take place throughout the month and across the State to promote and support breastfeeding. Communities have a variety of special activities planned, including Nursing Nooks at local fairs, and a walk at the Springfield Zoo.

WIC is the Special Supplemental Nutrition program for (low-income) Women, Infants and Children that provides nutrition information, supplemental foods and referral to other health and social services for the target population. The WIC program in Illinois currently provides services each month to approximately 250,000 women, infants and children. Breastfeeding information and support is also provided to families. The WIC program works closely with the Family Case Management program to assure that families are receiving services for identified needs.

WIC continues to provide technical assistance and consultation on breastfeeding promotion,

support and management for health departments and local agencies administering WIC programs statewide. During the last five years, DHS has trained more than 900 local agency staff in breastfeeding promotion and support techniques. Through various programs, including weeklong intensive training and one-day workshops, staff have received advanced training in breastfeeding counseling and problem-solving. Breastfeeding training opportunities have been extended to other organizations providing services to both MCH clients. We partner with these agencies in area coalitions and task forces and help train their staff to provide "correct" breastfeeding information to our WIC clients. Over 380 local agency staff and community partners attended the 2005 State Breastfeeding Conference "Over the Rainbow to Breastfeeding Gold". The conference focused on increasing initiation and duration rates to meet the Healthy People 2010 breastfeeding goals.

DHS continues to promote and support the activities of the Regional Breastfeeding Task Forces throughout the state, collaborating with hospitals, area community groups, and breastfeeding advocacy organizations. An example of this collaboration is the "Mobile Nursery," a self-contained mobile home which provides a comfortable, convenient location for breastfeeding mothers as they visit area fairs. The "Mobile Nursery" has been used at several fairs throughout the state and serves the public by providing a cool, clean place for families to take a nursing break while also providing breastfeeding education to the general public.

A current project of the State Breastfeeding Task Force and DHS is a billboard display using the National Ad Campaign, "Babies Were Born to Be Breastfed." Seven billboards strategically placed around the Capitol City were displayed during May. During August, a month when the Capitol City hosts the state fair, an additional seven billboards will be displayed. We still collect breastfeeding data in Cornerstone.

### c. Plan for the Coming Year

The program strategies used in FFY'05 will continue in FFY'06

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | 90 | 70 | 75 | 95 | 100 |
| Annual Indicator | 57.8 | 55.3 | 64.7 | 86.9 | 95.3 |
| Numerator | 107000 | 101764 | 116819 | 159805 | 169333 |
| Denominator | 185003 | 184022 | 180555 | 183899 | 177603 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 96 | 97 | 98 | 99 | 100 |

**Notes - 2002**

It is estimated that 60 percent of newborns were screened for hearing in 2001.

**Notes - 2003**

Revised note for CY2003: This was the first year of the mandated law for universal newborn hearing screening in Illinois. Of the 163,621births reported by participating hospitals, 159,805 infants (or 98 percent) were screened. "Annual performance" compares the reported number screened to the number of occurrent births.

**Notes - 2004**

In 2004 the number of newborns screened has increased 6 percent from last year. The denominator is the preliminary estimate of occurrent births for 2004 as reported in Form 6.

## a. Last Year's Accomplishments

During calendar year 2004, the percentage of newborns screened for hearing loss and reported to IDPH improved. The number of newborns screened prior to discharge represents 94 percent of the estimated total births in Illinois and 98 percent of the births reported to the IDPH newborn hearing screening program through the use of HI*TRACK. Based on the recent annual average number of births, it is estimated that 99 percent (172,092) were reported to the newborn hearing screening program. Results for these reported newborns show 169,565 (99 percent) were screened prior to discharge, 2,077 (one percent) were not screened prior to discharge, and 560 (.003 percent) were reported as deceased. Of the 169,143 screened and reported, 7,256 (four percent) were referred for further audiological evaluation or outpatient screening. Of the 7,276 (four percent) referred from the inpatient screening, 6,985 (96 percent) passed an outpatient screening and 416 (six percent) went directly to audiological diagnostic testing. Of the 1,967 not screened prior to discharge, 515 (25 percent) were too ill to be screened and were transferred to another facility prior to screening. Of the 2,077 not screened prior to discharge, 1,053 (51 percent) passed the outpatient screening, 32 (two percent) went directly for audiological diagnostic testing, and 29 (.001 percent) expired. The number of children born in 2004 with confirmed congenital hearing loss was 71. The average age of diagnosis was 3.2 months with the median age was 2.6 months.

The three state agencies collaborating on the newborn hearing screening initiative in Illinois hosted a "Think Tank Day" in June 2004 that involved key stakeholders in the system. Participants included staff from birthing hospitals, local health departments, audiologists, ICAAP, Early Intervention, advocacy groups, ICAAP UNHS Chapter Champions, Illinois Public Health Association (IPHA), DSCC, IDHS, and IDPH. The participants identified barriers in the various stages of the process and recommended strategies to address them. The main themes that emerged were: 1) the process is not understood by parents, physicians, audiologists, or service/care coordinators from the Early Intervention and Title V programs; 2) there are inadequate numbers of audiologists that have the training and equipment for evaluating newborns in some areas of the state; and 3) research/ tracking of children through the process. The state agencies developed plans for addressing these issues using recommendations from the stakeholders. Plans include developing a website with information and resources for parents and professionals, training for physicians and audiologists, and increased emphasis on reporting by hospitals, audiologists, and physicians. Also, the three agencies determined that DSCC should apply for the next MCHB Universal Newborn Hearing Screening grant and hire an audiologist to lead the state's system building efforts.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| | **Pyramid Level of** |
|---|---|

| Activities | Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
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b. Current Activities

As of March 8, 2005, data reported for the first two months of calendar year 2005 indicate 24,434 births with 23,857 (98 percent) screened prior to discharge, 515 (2 percent) not screened prior to discharge, and 62 (0.25 percent) deceased. While data continues to arrive and follow-up is only beginning for the 808 (3 percent) of infants referred, and the 515 not screened, two infants born in 2005 have already been identified with sensorineural hearing loss. The average and median ages for these two children was 0.4 months, or 12 days.

DSCC is now the recipient of Illinois' Universal Newborn Hearing Screening program grant from the federal Maternal and Child Health Bureau. DSCC uses these funds to support an audiologist to oversee day-to-day program operations, including public awareness activities, training of audiologists, physicians, local health
departments, and other participants in the follow-up system. DSCC has disseminated the "Sound Beginnings" vide to all birthing hospitals and local health departments for use in prenatal classes and obstetric units. Public awareness resources are being developed, such as newborn hearing website and clearinghouse, displays for use at professional conferences and health fairs, and fact sheets for physicians and families.

c. Plan for the Coming Year

IDHS, IDPH, and DSCC will continue to collaborate on system issues in the state with special focus on communities lacking adequate audiology resources. Strategies will include trainings around the state for audiologists on the referral and reporting processes and pediatric diagnostic and intervention procedures, collaboration with the ICAAP "Chapter Champion" to provide in-service programs or grand rounds for physicians and residents, training and informational resources for DSCC care coordinators and Early Intervention service coordinators, identification of parent support networks and continuing support for the website and clearinghouse.

Performance Measure 13: *Percent of children without health insurance.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual** | | | | | |

| Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 8.9 | 7.4 | 6.9 | 6.9 | 6.8 |
| Annual Indicator | 6.7 | 6.9 | 7.0 | 6.8 | |
| Numerator | 223000 | 228100 | 235000 | 231000 | |
| Denominator | 3341000 | 3329000 | 3363000 | 3408000 | |
| Is the Data Provisional or Final? | | | | Provisional | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 6.7 | 6.6 | 6.6 | 6.5 | 6.5 |

**Notes - 2002**

The latest data reported in column year 2002 corresponds to the data released for the 3-year-averages of 2001, 2002 and 2003 (Source: Low Income Uninsured Children by State report that is released by the U.S. Census Bureau). The state has routinely reported this data in the column that corresponds to the middle year.

**Notes - 2003**

The final data for FY2003 will be reported with the release of the Low Income Uninsured Children by State: 2002, 2003 and 2004. Number and percent of children less than age 19 at or below 200 percent of poverty by state. U.S. Census Bureau. The source of the provisional data for FY2003 is Table HI10. Number and percent of children under 19 at or below 200% of poverty by health insurance coverage and state: 2003. U.S. Census Bureau, Current Population Survey, 2004 March Supplement.

**Notes - 2004**

The final data for 2004 will be reported with the release of the Low Income Uninsured Children by State: 2003, 2004 and 2005. Number and percent of children less than age 19 at or below 200 percent of poverty by state. U.S. Census Bureau. The source of the provisional data for FY2004 is Table HI10 (not available at the time this application is being prepared). Number and percent of children under 19 at or below 200% of poverty by health insurance coverage and state: 2004. U.S. Census Bureau, Current Population Survey, 2005 March Supplement. The Annual Performance Objective for 2004 will be changed to 6.7 percent.

## a. Last Year's Accomplishments

Illinois exceeded its goal of reducing the proportion of children without health insurance to 6.9 percent in 2003. Actual performance was 6.8 percent.

Illinois addresses this performance measure by promoting enrollment in KidCare, Illinois' health insurance program for children. IDHS launched an initiative to increase insurance coverage of children in the WIC program. When this project began in September 2000, a total of 86 percent of WIC-enrolled infants and children were documented in the Cornerstone system as having KidCare or private insurance coverage. Due to the continued efforts of WIC local agency staff, this proportion has steadily increased. By September 2004, 87 percent of WIC-enrolled infants and children in Cook County and 94 percent of WIC-enrolled infants and children downstate were documented in the Cornerstone system as having enrolled in KidCare or private health insurance.

Governor Blagojevich increased the income eligibility threshold for KidCare to 200 percent of the federal poverty level effective July 1, 2003. The income eligibility threshold for FamilyCare was increased to 133 percent of the federal poverty level effective September 2004, and will increase to 185 percent of the federal poverty level in January 2006. The IDHFS implemented Medicaid Presumptive Eligibility for children in May 2004.

KidCare has a number of enrollment coordination initiatives. These include work with school districts throughout the state to find children who are eligible through the free and reduced price school lunch program. KidCare continues to work with WIC, Child Care Resource and Referral agencies, Chicago Public Schools, the Food Stamp program, and the Early Intervention program.

All families enrolled in the Food Stamp program were contacted by IDHS and KidCare enrollment information was provided if the family was not currently enrolled in the KidCare program.

Covering Kids and Families Illinois (CKF-IL) is a statewide coalition that works to enroll all eligible children and their families in KidCare, Medicaid, and FamilyCare health plans. The coalition brings together leaders in health, education, business, government, faith, and social service organizations to educate working families about state-funded health insurance programs. The Illinois Maternal and Child Health Coalition (IMCHC) serves as the lead agency for CKF-IL and two community demonstration projects. The project is supported by a grant from the Robert Wood Johnson Foundation.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
| 2. | | | | |
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## b. Current Activities

As a part of the MCH program's performance management strategy, uninsured children who are participating in the WIC program are targeted for additional follow-up to ensure that their families have the opportunity to enroll in KidCare. The number and proportion of uninsured pediatric WIC participants is monitored on a quarterly basis and the information is distributed to local WIC agencies for management purposes.

## c. Plan for the Coming Year

IDHS and IDHFS will continue to promote enrollment in KidCare to reduce the proportion of children without health insurance. IDHS will use the Cornerstone system to monitor the number

of WIC/FCM-eligible children who do not have insurance coverage. These children will be targeted by local WIC and Family Case Management grantees for additional outreach efforts to encourage their parents to enroll them in KidCare. IDHFS will continue to provide training and field staff support to KidCare Application Agents. School-Based/School-Linked Health Centers will determine insurance status of all enrolled students and refer those without insurance to KidCare. IDHFS is in the process of developing a web-based application so that families can apply for KidCare or FamilyCare online.

In addition, the Healthy Child Care Illinois Program Child Care Nurse Consultants provide KidCare enrollment information to all of Illinois' child care providers and families who attend outreach education programs. Approximately 6,000 applications and informational packets were distributed in SFY'04.

IDPH requires Dental Sealant programs to educate and enroll families in KidCare.

Chicago. Through its clinics, home visiting programs, collaboration with other organizations and health fairs, CDPH staff will continue to increase its emphasis on enrolling eligible individuals in KidCare.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 72 | 83 | 84 | 87 | 89 |
| Annual Indicator | 80.8 | 80.2 | 70.0 | 73.1 | |
| Numerator | 812694 | 867319 | 483235 | 521974 | |
| Denominator | 1005451 | 1082020 | 690015 | 713888 | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 74.5 | 74.5 | 75 | 75 | 75.5 |

**Notes - 2002**

Source: CMS-416 Annual EPSDT Participation Report, FFY2003.
New Source Detail: Total Eligibles Receiving at Least One Initial or Periodic Screen (Line 9) of Total Eligibles Who Should Receive at Least One Initial or Periodic Screen (Line 8). The resulting annual indicator matches the Participation Ratio (Line 10) of the report.

**Notes - 2003**

Source: CMS-416 Annual EPSDT Participation Report, FFY2003.
New Source Detail: Total Eligibles Receiving at Least One Initial or Periodic Screen (Line 9) of

Total Eligibles Who Should Receive at Least One Initial or Periodic Screen (Line 8). The resulting annual indicator matches the Participation Ratio (Line 10) of the report.

The revised proportion will replace past reporting for this measure of Total Screens Received (Line 6) and Total Individuals Eligible for EPSDT (Line 1) of the above-named report. These resulting percentages are higher. The Annual Performance Objectives for FY2003 and 2004 will be reset at 73.0, the most current estimate of participant ratio. FY2005-2009 have also been reset accordingly.

Because TVIS restricts revision of data for prior years, FY2000 and 2001 revised proportions will be sent to the HRSA Call Center for update to the Illinois database.

**Notes - 2004**

Data for 2004 were not available at the time this application was being prepared. The 2004 Annual Performance Objective will be changed to 74 percent.

## a. Last Year's Accomplishments

Illinois revised its method of measuring the proportion of children who are eligible for the Medicaid program who received a service that Medicaid paid for. Actual performance was 73.1 percent. (Data from FFY'03 CMS Form 416 were the most recent data available at the time of submission.) The performance data were revised to use the EPSDT participation rate from the CMS 416 as the performance indicator.

FCM agencies conduct community outreach to identify families with Medicaid- eligible pregnant women or KidCare-eligible children and inform them of available services. Case managers work with individual families to decrease the barriers in obtaining healthcare services (i.e., transportation, child care, lack of information about Medicaid and KidCare). Also, through the HealthWorks of Illinois program, 100 percent of wards in downstate Illinois had received a comprehensive health evaluation.

Chicago. The CDPH received a CAPS grant through the Bureau of Primary Health Care, part of which was used during CY 2003 to fund six community agencies. They successfully conducted outreach and enrolled over 6,800 individuals into the KidCare Program. They also referred many clients to providers for health services. This program continued through April of 2004. The case management and outreach staff and CDPH clinic staff all ensure that children who present for care are screened for eligibility. KidCare applications are initiated and submitted for all eligible children. Case managers, public health nurses and outreach workers ensure that children are appropriately enrolled, and linked with a service provider. The CDPH bills KidCare for services provided to eligible children.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. | | | | |
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b. Current Activities

Children in the foster care system are at increased risk for under-utilization of preventive, primary and specialty health care services. IDHS, IDCFS, and IDHFS developed HealthWorks of Illinois (HWIL) to improve access to health care services for children in foster care. HealthWorks for Chicago is being reorganized during FY'05. The Initial Comprehensive Health Exam and the medical case management will be assigned to medical providers and case management agencies based on the ZIP Code of the foster parent. The goal of the reorganization is to assure children receive all components of the comprehensive exams at one location so that foster parents do not have to have multiple appointments. Foster parents and case managers will have contact with fewer medical clinics and the information will be easier to obtain.

c. Plan for the Coming Year

Improving participation in the Medicaid program will be addressed through the Family Case Management, Healthy Start, Healthy Families Illinois, HealthWorks of Illinois, Healthy Child Care Illinois, Teen Parent Services, Responsible Parenting and Subsequent Teen Pregnancy Prevention programs and the School-Based/School- Linked Health Centers. Once enrolled, parents are encouraged and assisted to obtain routine care for their children. Children who require specialized services are assisted with enrollment in the Early Intervention program, the CSHCN program or referred for other specialized care.

Chicago. CDPH case management and outreach staff and CDPH clinic staff will continue to ensure that children who present for care are screened for eligibility, and will submit Medicaid applications for all eligible children. Case managers, public health nurses and outreach workers will ensure that children are appropriately enrolled, and linked with a service provider.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| **Annual Objective and Performance Data** | **2000** | **2001** | **2002** | **2003** | **2004** |
|---|---|---|---|---|---|
| Annual Performance Objective | 1.7 | 1.7 | 1.6 | 1.6 | 1.6 |
| Annual Indicator | 1.7 | 1.6 | 1.7 | 1.6 | |
| Numerator | 3067 | 2875 | 3019 | 2946 | |
| Denominator | 185003 | 184022 | 180555 | 182393 | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Performance Objective | 1.6 | 1.6 | 1.5 | 1.5 | 1.5 |

**Notes - 2002**

2002 vital records data was not available at the time this application was being prepared.

**Notes - 2004**

2004 vital statistics from the Illinois Department of Public Health were not available at the time this application was being prepared. These data will be available in 2006.

## a. Last Year's Accomplishments

Illinois achieved its goal of reducing the very low birth weight rate to 1.6 percent of live births in 2003. Actual performance was 1.6 percent.

To address this performance measure, the Department has continued to emphasize "integrated" delivery of WIC and FCM services. The very low birth weight rate among women who participated in both programs was 1.3 percent in 2003, less than a third of the rate (4.0 percent) observed among Medicaid-eligible women who did not participate in either program during pregnancy.

The Targeted Intensive Prenatal Case Management projects target women with one or more medical or social risk factors for low birth weight. During the project's first year, the low birth weight rate among participants was 18 percent. By the second year it had dropped to 16 percent, and by the third year to 12 percent. The total number of clients served increased each year.

A "Closing the Gap" grant application to address the disparities for African-American women was submitted in June 2004. (Program strategies are summarized below.)

Several other programs addressed this performance measure. School-Based/School-Linked Health Centers referred pregnant students for prenatal care and monitored their use of services. Family Planning delegate agencies provided pregnancy testing, informed patients of the importance of early prenatal care, and made referrals to prenatal care providers. The Healthy Child Care Illinois project's Child Care Nurse Consultants refer families to primary care providers and to health programs such as WIC, KidCare, FCM, HFI, and TPS. The Targeted, Intensive Prenatal Case Management project has been implemented in ten communities with high Medicaid expenditures during the first year of life.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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## b. Current Activities

The integrated delivery of the FCM and WIC programs is having a major impact on the state's infant mortality rate and health care expenditures: -six consecutive annual program evaluations have shown that the health status of infants born to Medicaid eligible women who participated in both WIC and Family Case Management has been substantially better than that of infants born to Medicaid- eligible women who did not participate in either program. In particular: the rate of premature birth is more than 60 percent lower among participants in both programs; the rate of low birth weight is more than 35 percent lower; the rate of infant mortality is more than 55 percent lower; and health care expenditures during the first year of life have been more than 40 percent lower. This univariate examination has been approved by multivariate approach, which found a significant improvement in premature birth rates among women who participated in both programs.

In March 2005, 98 percent of downstate WIC clients and FCM clients were receiving integrated services. Program integration has been more challenging in Cook County, since WIC and FCM use different providers to serve this part of the state. As of March 2005, 89 percent of WIC clients and 92 percent of FCM clients in suburban Cook County, and 83 percent of WIC clients, and 89 percent of FCM clients in the city of Chicago were receiving integrated services. This integrated system now serves nearly 40 percent of the infants born in Illinois each year. It has saved the lives of hundreds of infants and reduced Medicaid expenditures by hundreds of millions of dollars.

Illinois was one of four states eligible for a grant under former Secretary Thompson's Closing the Gap initiative to reduce racial disparities in infant mortality through the use of evidence-based interventions. Illinois' project targets four communities on the West side and three communities on the South side of the City of Chicago. The project includes:

Working with the two Healthy Start projects and other Title V grantees that serve these communities;

Developing culturally appropriate strategies for health education to reduce the risk of premature birth and Sudden Infant Death Syndrome;

Improving the quality of patient care provided to pregnant women who are at risk of giving birth prematurely; and

Using peer educators to influence community norms on the use of prenatal care and infant sleeping arrangements.

## c. Plan for the Coming Year

The IDHS Family Case Management, WIC Chicago Healthy Start, Perinatal Care, Problem Pregnancy, Targeted Intensive Prenatal Case Management programs and the School-Based/School-Linked Health Centers will continue their efforts to reduce the very low birth weight rate by ensuring that women initiate prenatal care early in pregnancy and by ensuring that women receive risk-appropriate prenatal care. The IDHS Family Planning program will continue to provide primary pregnancy prevention through reproductive health education and prompt referral for prenatal care. Closing the Gap will be fully implemented during FY'06.

Chicago. The percentage of very low birth weight infants has remained fairly stable in Chicago, trending slightly downward for all racial ethnic groups. The percentage of infants with very low birth weights was 3.6 percent in 2002, and 3.5 percent in 2003 among Non-Hispanic Blacks;

1.5 percent and 1.2 percent respectively in 2002 and 2003 among Non-Hispanic Whites, and 1.3 percent and 1.1 percent respectively among Hispanics.

CDPH will continue case management of high-risk maternal clients to assure that they are followed in the appropriate settings, and that they receive the support services they need to prevent pre-term delivery, the major contributing factor for very low birth weight live births. Public health nurses and case managers in IDHS Targeted Intensive Prenatal Case Management Program, the federal Healthy Start Program, the Community Development Block Grant outreach programs, and in the IDHS Chicago Family Case Management program will continue to help high-risk pregnant women access services. CDPH's Healthy Start program will continue to work closely with Chicago's Closing the Gap Initiative, with emphasis on collaboration among all community agencies and services and community-wide education about infant mortality. Women will be encouraged to enroll in family planning programs to space their pregnancies, thus increasing their chances of giving birth to a healthier baby. WIC staff will identify correctable nutritional risk factors and will encourage women to gain an appropriate amount of weight during their pregnancy.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 7 | 7 | 6.9 | 5.4 | 5.4 |
| Annual Indicator | 5.8 | 6.9 | 5.4 | 5.4 | |
| Numerator | 52 | 62 | 48 | | |
| Denominator | 894002 | 899400 | 888890 | | |
| Is the Data Provisional or Final? | | | | Provisional | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 5.4 | 5.3 | 5.3 | 5.2 | 5.2 |

**Notes - 2002**

2002 vital records data were not available at the time the application was being prepared.

**Notes - 2003**

The 2003 vital records data were not available at the time this application was being prepared. These data will be available at the end of CY2005 from the Center for Health Statistics, IDPH. Since TVIS requires an estimate be made for 2003, the 2002 rate is again being reported.

**Notes - 2004**

The 2004 vital records data were not available at the time this application was being prepared. It is not known when these data will be available from the Center for Health Statistics, IDPH.

## a. Last Year's Accomplishments

Illinois achieved its objective of reducing the rate of suicide among 15 to 19-year-olds. The target rate was 6.9 per 100,000 and actual performance was 5.4 per 100,000 in 2002. (This was the most recent information available at the time of submission.)

All 38 School-Based and School-Linked Health Centers provide mental health counseling on-site and/or have agreements with outside community providers for individual, group, or inpatient care as needed. Several centers, faced with students in crisis and with limited time and appointment access, worked with local hospitals to set up a tele-health system. The psychologist sets up an appointment with a psychiatrist via video for the psychiatrist to talk to the student in crisis and provide immediate care with an ongoing care plan to follow. The psychiatrist is also available for consultation with the school health staff through the tele-health system. Health educators and ancillary staff provide additional support via small group meetings, adult mentors, peer mentors, peer support groups, parent and child activities, recognition of accomplishments, and building self-esteem. The programs assisted students in setting and achieving long and short-term goals, thereby fostering hope and reducing the likelihood of contemplating suicide.

The mental health committee within the Coalition for School-Based Health Centers developed and distributed to the centers a document entitled "Suicide Assessment and Management: Guidelines for Illinois SBHCs." Training was provided via satellite to DCHP staff and contractors on signs, causes, and referral procedures on adolescent suicide.

The task force sponsored a statewide suicide prevention conference.

Teen Parent Services continues collaboration efforts with both the Bureaus of Community-Based and Primary Prevention and Domestic and Sexual Violence Prevention in the Office of Prevention to promote access to prevention, assessment, and treatment for TPS participants statewide. Access to these services provide an avenue for substance abuse screening, assessments, treatment, referrals, and monitoring. In addition, this collaborative effort provides access to drug, alcohol, and tobacco education as important components of the early intervention strategies.

The Illinois Suicide Prevention Task Force reached consensus on the top ten needs in Illinois and set them as overriding objectives for implementation of the state's strategic plan. The Task Force and IDPH worked toward passing legislation that named the Suicide Prevention Strategic Planning Committee as "official grassroots creator, planner, monitor, and advocate" for the strategic plan.

An important accomplishment is passage of legislation through the General Assembly during the 2004 legislative session. It was sent to the Governor for signature in mid June. Part of the legislation requires the Illinois Department of Public Health to carry out much of the work that has already been accomplished by the committee.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
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| | DHC | ES | PBS | IB |
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b. Current Activities

The OFH is active with the Illinois Suicide Prevention Committee, part of the Illinois Injury Prevention Coalition. Program development staff assisted in the development of ten overarching recommendations that apply to all areas of the Illinois Strategic Suicide Prevention Plan, particularly to encourage school personnel to screen for suicidal ideation and intention and to establish suicide education curriculum requirements for public service professionals.

c. Plan for the Coming Year

IDHS will continue to work with the Illinois Coalition of School-Based/School-Linked Health Centers to increase services. A standard database has been developed to maintain an accurate record of mental health services provided at each site. Preventive health education activities will be increased. Comprehensive School Health Projects utilize the eight components of a Coordinated School Health Program Model to provide prevention activities. These programs and activities focus on self-esteem, violence prevention, student assistance programs, alcohol/substance abuse prevention, sexual abuse, and date rape prevention.

The School-Based/School-Linked Health Centers will continue to identify troubled youth and provide care directly or by referral to other services.

IDHS will continue to collaborate with the Department of Children and Family Services (DCFS) to provide children in its custody with mental health services in areas such as trauma, substance abuse, developmental disabilities and integrated assessment as required by recent legislation signed into law in June 2005 (House Bill 759: Public Act 94-0034).

Through use of discretionary funds, IDPH will monitor the prevention strategies as outlined in the Suicide Prevention, Education, and Treatment Act. It is hopeful that IDPH receives funding from SAMSHA to carry out these objectives. Currently five pilot projects have been implemented in Illinois. Statewide implementation of suicide prevention programs is the goal.

Illinois has 12 certified local crisis centers that are part of the National Hopeline Network and eight mutual local crisis centers that are part of the National Prevention Lifeline Network. It is anticipated that the National Prevention Lifeline Network, the federal grant recipient that funded the National Hopeline Network for the past three years, will be promoted in future educational brochures. The plan for network consolidation is not known. Illinois should be developing a better, coordinated, and comprehensive crisis hotline system. There are more small local crisis centers currently not part of any network. It is not known whether each of the centers follows consistent guidelines for crisis situations.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

| Tracking Performance Measures |
|---|

*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 74.5 | 75 | 78 | 82 | 82 |
| Annual Indicator | 74.5 | 77.3 | 81.9 | 82.5 | |
| Numerator | 2286 | 2222 | 2473 | 2430 | |
| Denominator | 3067 | 2875 | 3019 | 2946 | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 83.5 | 84 | 84.5 | 85 | 85.5 |

**Notes - 2002**

2002 vital records data were not available at the time this application was being prepared. The numerator contains VLBW births delivered at Level II+ and Level III facilities in Illinois.

**Notes - 2003**

Source: Number of VLBW births delivered at Level II+ and Level III facilities in Illinois during 2003, Illinois Department of Public Health, Perinatal Program.

**Notes - 2004**

Data for 2004 were not available at the time the 2006 application was being prepared.

## a. Last Year's Accomplishments

Illinois did not achieve its goal for this performance measure. The target was 82 percent and actual performance in 2003 was 82.7 percent.

Primary responsibility for directing the Illinois Perinatal Program was shifted back to the Illinois Department of Public Health. This has lead to improved coordination between the Department and the Perinatal centers, their community hospitals and related physicians. IDPH is working with the IDHS on the implementation and coordination of other MCH/perinatal programs and activities, such as the Fetal and Infant Mortality Review (FIMR) Project, Early Intervention (EI) Program, the Chicago Healthy Start Initiative, and the new Closing the Gap project.

IDPH and the Statewide Quality Council have worked very closely with each of the ten perinatal networks on the monitoring and evaluation of the percentage of the very low birth weight infants born in a Level II+ or Level III facility. The methodology for incorporating perinatal outcome surveillance and plans for improving provider compliance with consultation, referral, and transfer protocols for high-risk maternal and neonatal patients are in place at all facilities, as well as the monitoring system for outcomes for the purpose of quality assessment and improvement.

Chicago. In 2003, 964 very low birth weight infants were born to Chicago residents. Of these, 793 (82.2 percent) were born at Level III and Level II+ hospitals, locations capable of providing care for these infants. CDPH does not have data to determine the percentage of infants who were born at inappropriate facilities but were transferred to more appropriate facilities.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
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| | DHC | ES | PBS | IB |
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## b. Current Activities

One of the major goals of the Perinatal Care Program (the regionalized perinatal care system) is to ensure that pregnant women and their infants receive care at the appropriate level facility. To ensure that, one measure is the number of very low birth weight infants delivered at, or immediately transferred to, an appropriate facility. The perinatal program has increased from 69 percent in 1969 to over 82 percent in 2003. Illinois is well positioned to reach the national goal of 90 percent by 2010.

## c. Plan for the Coming Year

Each of the ten perinatal networks, as well as IDPH and the Statewide Quality Council, will continue to monitor and evaluate the percentage of very low birth weight infants born at appropriate facilities, and in-depth educational opportunities will be given to those facilities who may have problems assessing those patients who
should be transferred to a higher level of care. Members of the Statewide Quality council as well as members of the Quality Improvement and Education Committee will continue to work together to establish and implement quality improvement plans that will lead to improved outcomes.

Chicago. The CDPH and members of the Chicago Maternal and Child Health Advisory Committee (CMCHAC) have participated in Perinatal Advisory Committee meetings and assisted in the development of perinatal rules and regulations. The perinatal centers and the CDPH will continue to monitor the Level II hospitals to assess the care provided to neonates.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

| Tracking Performance Measures<br>*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual Objective and Performance** | **2000** | **2001** | **2002** | **2003** | **2004** |

| Data | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 81 | 81 | 82 | 83 | 84 |
| Annual Indicator | 80.7 | 81.9 | 82.8 | 82.0 | |
| Numerator | 149237 | 150690 | 149495 | 149587 | |
| Denominator | 185003 | 184022 | 180555 | 182393 | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 84 | 85 | 86 | 87 | 88 |

**Notes - 2002**

2002 vital records data was not available at the time this application was being prepared.

**Notes - 2004**

2004 vital statistics from the Illinois Department of Public Health were not available at the time this application was being prepared. There are no timeframes when these data will become available.

## a. Last Year's Accomplishments

Illinois did not meet its objective to increase the proportion of women who began prenatal care in the first trimester of pregnancy to 83 percent. Actual performance was 82 percent in 2003.

A 2003 program evaluation found that the rate of early initiation of prenatal care among WIC and FCM program participants (75.8 percent) was 14 percent higher than the rate among Medicaid-eligible women who did not participate (65.9 percent).

The Teen Parent Services program has assisted in addressing this goal through its integration and collaboration with the Family Case Management program. Upon identification, eligible pregnant teens are immediately referred for Family Case Management services in those agencies that do not provide both programs.

The goal of IDHFS's Medicaid Presumptive Eligibility (MPE) program is to promote early and continuous prenatal care to low-income pregnant women. Through presumptive eligibility, women are covered for prenatal care services from the date of the MPE determination. (That determination made by MPE providers begins the application process for ongoing assistance under Title XIX with the KidCare application completed at the same time.) Approximately 3,800 women are enrolled in MPE each month.

One component of the Problem Pregnancy program is outreach to enroll high-risk women into prenatal care as quickly as possible. Seventy percent of the women served by the Problem Pregnancy Program in SFY'04 began prenatal care during the first trimester, which reflects their high-risk status.

Chicago. Entry into prenatal care continues to improve for Non-Hispanic Whites and Hispanics. There has been consistent improvement for Non-Hispanic Blacks as well; however, 2003 saw a slight decrease for African-American Women. Between 2002 and 2003, the percentage of Non-Hispanic Whites initiating prenatal care during the first trimester increased from 90.2 percent to 90.4 percent; for Hispanics the increase was from 80 percent to 82.3 percent. For Non-

Hispanic Blacks the percentage was 72.6 percent in 2001, 74.1 percent in 2002, and decreased slightly to 73.7 percent in 2003.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
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## b. Current Activities

The Title V program uses several strategies to increase the proportion of women who begin prenatal care in the first trimester, including referrals from Family Planning programs, outreach and case finding activities through Family Case Management, integration of WIC and Family Case Management services, integration of Teen Parent Services and Family Case Management programs, and the operation of school-based health centers.

Targeted Intensive Prenatal Case Management continues to serve high-risk pregnant women. During FY'05 the project added the communities of South Shore, South Chicago, Woodlawn and Austin. The expansion has increased the number of communities served from 16 to 20.

Chicago. CDPH's strategies of promoting postpartum and family planning visits to decrease unplanned pregnancies; enrolling women in care following a positive pregnancy test result; and encouraging newly-pregnant women to continue in care will help reduce the number of women who delay early enrollment into prenatal care.

When possible, women will receive support services such as tokens for transportation to enable them to keep appointments.

## c. Plan for the Coming Year

The Title V program uses several strategies to increase the proportion of women who begin prenatal care in the first trimester. Family Planning agencies routinely provide options counseling to women with a positive pregnancy test and refer women to prenatal care providers as appropriate. Local IDHS office staff are being trained to routinely ask women of childbearing age if they are pregnant and, if so, to record this information in the department's data system. This information is then shared with FCM and Chicago Healthy Start Initiative (CHSI) agencies so staff can conduct outreach efforts and assist women with obtaining prenatal care. The Department will also continue using community-based agencies in Chicago to contact pregnant Medicaid-eligible women regarding WIC and FCM services, improve working relationships between these local providers and DHS' local offices, and to monitor enrollment in WIC and

FCM by trimester of pregnancy. These strategies should increase the proportion of Medicaid-eligible pregnant women who participate in WIC and FCM and initiate prenatal care in the first trimester. At the Governor's request, the Illinois General Assembly provided an additional $1.9 million for the Targeted Intensive Prenatal Case management project. Title V and Title XIX staff are reviewing indicators of need for the allocation of these funds.

The Bureau of Child and Adolescent Health will continue to coordinate and integrate services with FCM agencies to ensure entry into early prenatal care for pregnant adolescents which will include, but not be limited to, early identification of pregnancy, education regarding the importance of early and timely prenatal care, reduction of risky behaviors that could affect the outcome of the pregnancy, provision of health care services, and case management and referral to reduce the barriers to health care.

Chicago. CDPH's strategies of: promoting postpartum and family planning visits to decrease unplanned pregnancies; enrolling women in care following a positive pregnancy test result; and encouraging newly-pregnant women to continue in care will help reduce the number of women who delay early enrollment into prenatal care. When possible, women will receive support services such as tokens for transportation to enable them to keep appointments.

CDPH has negotiated contracts with seven hospitals to provide midwifery-based prenatal and family planning services in five of its Neighborhood Health Centers.

## D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The proportion of live births who receive adequate prenatal care, as measured by the Modified Kessner Index*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 74.0 | 74.0 | 75 | 75 | 75.5 |
| Annual Indicator | 73.1 | 74.5 | 75.1 | 74.4 | |
| Numerator | 135229 | 137153 | 135675 | 135710 | |
| Denominator | 185003 | 184022 | 180555 | 182393 | |
| Is the Data Provisional or Final? | | | | Final | |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance | 75.5 | | | | |

| Objective | | | | | |
|---|---|---|---|---|---|

**Notes - 2002**

2002 vital records data were not available at the time the application was being prepared.

**Notes - 2004**

2004 vital statistics from the Illinois Department of Public Health were not available at the time this application was being prepared. There are no timeframes for when these data will become available.

## a. Last Year's Accomplishments

This performance measure was chosen because of its relationship to infant mortality (a priority health problem) and to highlight the importance of prenatal care. It is at the enabling service level of the pyramid, addresses the population of pregnant women, and addresses a risk factor for infant mortality.

Illinois did not meet its 2003 performance target of 75 percent for this objective. The proportion of women who received an "adequate" amount of prenatal care in 2003 was 74.4 percent.

This measure was addressed primarily by the FCM, WIC, Targeted Intensive Prenatal Case Management, and Chicago Healthy Start programs. The Department uses the Cornerstone management information system to improve local providers' performance on early and continuous utilization of prenatal care. The Department distributes quarterly reports on enrollment in WIC and Family Case Management by trimester of pregnancy to grantees statewide. Each FCM agency is developing a closer working relationship with the Department's local offices that enroll people in KidCare, TANF, Food Stamps and other services to decrease the length of time between a pregnant woman's enrollment in KidCare and referral to Family Case Management.

In addition, the Parents Too Soon (PTS), Teen Parent Services (TPS), Responsible Parenting, Subsequent Teen Pregnancy Prevention, Doula, and School-Based/ School-Linked Health Center programs promote early initiation of prenatal care and work with pregnant teens to ensure they continue to receive care throughout pregnancy.

Women who participated in FCM or WIC during pregnancy in 2003 completed more prenatal care visits than women who did not participate. When compared to Medicaid-eligible women who did not participate in either program during pregnancy in 2003, the proportion of women who received an "adequate" amount of prenatal care (using the Kessner Index) was 11.1 percent higher (65.3 percent vs. 54.2 percent).

Chicago. The percentage of women who receive adequate prenatal care has fluctuated, but remains below the Healthy People 2010 objective of 90 percent. In 2003, 63.0 percent of Non-Hispanic Blacks received adequate prenatal care, 25.5 percent received intermediate prenatal care, and 11.5 percent received inadequate prenatal care. The respective rates for Non-Hispanic Whites that year were 82.3 percent, 15.1 percent and 2.6 percent. Similarly, the respective rates for Hispanics were 72.5 percent, 23.1 percent and 4.4 percent. Since 1996, the CDPH has been implementing outreach programs to increase early enrollment into prenatal care among high-risk women in communities with high infant mortality rates. CDPH also operates a federally funded Healthy Start project that serves two community areas on the city's south side. This is one of four Healthy Start projects in the city of Chicago.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
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| | DHC | ES | PBS | IB |
|---|---|---|---|---|
| 1. 1. FCM and other case management programs advocate for women to complete an appropriate number of prenatal care visits | | X | | |
| 2. The Chicago Department of Public Health and school-based health centers provide prenatal care. | X | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

This performance measure will be addressed through the FCM and WIC programs, the Doula Project, School-Based and School-Linked Health Centers, the Parents Too Soon program, the Responsible Parenting program, and the Teen Parent Services program.

Chicago. Case managers and case manager assistants, public health nurses, and outreach workers encourage women to enroll and remain in prenatal care until delivery.

c. Plan for the Coming Year

This performance measure is discontinued.

State Performance Measure 2: *The proportion of women experiencing a live birth who have had a live birth in the prior eighteen months*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 16.5 | 16.0 | 16.0 | 17.4 | 17.2 |
| Annual Indicator | 17.8 | 17.6 | 17.6 | 17.8 | |
| Numerator | 20042 | 19755 | 18951 | 19065 | |
| Denominator | 112689 | 112066 | 107911 | 107330 | |
| Is the Data Provisional or Final? | | | | Final | |
| | 2005 | 2006 | 2007 | 2008 | 2009 |
| Annual | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Performance Objective | 17 | | | | |

**Notes - 2002**

2002 vital records were not available at the time the application was being prepared.

**Notes - 2003**

The data from 1999 through 2002 have been adjusted to reflect the corrected definition of the denominator in the revised detail sheet for this measure.

**Notes - 2004**

2004 vital statistics from the Illinois Department of Public Health were not available at the time this application was being prepared. There are no timeframes when these data will become available.

## a. Last Year's Accomplishments

Rationale. This performance measure was chosen because of its relationship to infant mortality (a priority health problem) and to highlight the importance of family planning services. It is at the direct service level of the pyramid, addresses the population of women of reproductive age, and is intended to prevent a risk factor for infant mortality.

Illinois did not achieve its goal of reducing the proportion of women with an interconceptional interval less than 18 months to 17.4 percent of all live births. Actual performance was 17.8 percent in 2003.

The Office of Family Health provided direct services to address this performance measure through the Family Planning Program. The IDHS also worked closely with the Illinois Department of Public Aid (now IDHFS) on the implementation of "Illinois Healthy Women," Illinois Medicaid waiver to provide4 family planning services to women who are loosing full Medicaid eligibility postpartum or are loosing Transitional Medicaid coverage following the loss of TANF benefits. These efforts assist women leaving the Medicaid program better prepare for economic independence by avoiding unintended pregnancies and reproductive health problems by assuring that women have access to comprehensive reproductive health care coverage, including annual physicals, pap smears, mammograms, contraceptives and treatment for sexually-transmitted diseases and providing women with the tools to better control the timing of their pregnancies with intention to improve the health of both moms and children. This new program helps women to have greater control over their lives at a time when they are focused on obtaining economic security for their families. In addition, the Responsible Parenting, Teen Pregnancy Prevention, School-Based/School-Linked Health Centers, Teen Parent Services, and the Parents Too Soon programs all provided services directly or by referral to address this performance measure; these programs focus exclusively on the teen population to ensure school completion and the attainment of self-sufficiency by delaying a subsequent pregnancy. Women served through the Family Case Management (FCM), Targeted Intensive Prenatal Case Management (TIPCM), and Healthy Start programs were assessed for family planning service needs, provided with information and referred for services.

Chicago. The proportion of women giving birth within an interval of less than 18 months has been decreasing steadily for all races since 1997; however, the level remained the same for Non-Hispanic Black women and there were slight increases for Hispanic and Non-Hispanic White women in 2003.

This objective is addressed by several case management programs in Chicago (including Healthy Start, Chicago Family Case Management, and CDPH outreach programs). CDPH has agreements with seven hospitals to use their midwives for prenatal and postpartum care in its clinics. Family planning services are provided by CDPH physicians if this is against hospital policy.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Family Planning programs help women choose the number and spacing of their children | X | | | |
| 2. FCM and other case management programs refer women to family planning services during the postpartum period. | | X | | |
| 3. WIC programs refer women to family planning services during the postpartum period. | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Family Planning program is working closely with IDHFS to match Title X and Medicaid billing data and assure maximum utilization of Medicaid resources. This may make Title X funds available to help serve adolescents, illegal immigrants, and women who have never been on Medicaid.

The Interconceptional Care component of Healthy Start extends the existing service system to a larger group of women. Healthy Start case managers will continue to provide information to women about infant healthcare, developmental stages of the infant, and parenting skills. Healthy Start case managers will also focus on helping women set and achieve goals in personal development during the 24 months after delivery. These goals may include going back to school, moving to better housing, finding a job, the planning of additional children, or not having additional children. The case manager works intensively with these women by having at least one face-to-face and one home visit each month with the client and by addressing the steps it will take to reach their identified goals.

c. Plan for the Coming Year

This performance measure is discontinued.

State Performance Measure 3: *The incidence of maltreatment of children younger than age 18*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | 10.0 | 9.5 | 9.0 | 7.9 | 7.8 |
| Annual Indicator | 9.2 | 8.3 | 7.9 | 7.9 | 7.8 |
| Numerator | 29333 | 26034 | 25160 | 25503 | 25423 |
| Denominator | 3187332 | 3120000 | 3185000 | 3220000 | 3259358 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 7.7 | 7.6 | 7.5 | 7.5 | 7.5 |

**Notes - 2002**

The 2002 number of unique children and the rate are the only data published by the Illinois Department of Children and Family Services for county and state indicated numbers of child abuse and neglect. The denominator is extrapolated from the number of unique children in the state to equal the published rate.

**Notes - 2003**

The 2003 number of unique children and the rate are the only data published by the Illinois Department of Children and Family Services for county and state indicated numbers of child abuse and neglect. The denominator is extrapolated from the number of unique children in the state to equal the published rate.

**Notes - 2004**

Data Source: Table 4 of the 2004 Annual Report of the Illinois Department of Children and Family Services (IDCFS). Number of children indicated is an unduplicated count within the State. IDCFS reports only the number of unique children and the rate per 1,000 which were used to calculate the denominator.

## a. Last Year's Accomplishments

This performance measure was chosen to promote healthy growth and development of children, a priority health problem. It is at the enabling level of the pyramid (since program services consist of interventions to improve parenting skills), addresses the population of children and adolescents, and is intended to reduce a risk factor for child morbidity and mortality.

Illinois met its goal for the reduction of child maltreatment. The rate of child maltreatment in 2003 was 7.9 per 1,000 children.

Healthy Families Illinois (HFI) is an intensive home visiting program to reduce the occurrence of child abuse and neglect. The Department currently supports 52 HFI programs throughout the state. The prevention of child abuse and neglect is also addressed by the Parents Too Soon and the High-Risk Infant Follow-up programs.

Chicago. According to the DCFS reports, the incidence of reported maltreatment of children consistently has declined: 7,424 children in FY'01, 7,108 children in FY'02, 6,558 children in FY'03, and 6,067 children in FY'04. Public health nurses and outreach workers are expected to assess clients and help mothers develop parenting skills. Through its Community Development Block Grant, the CDPH monitors several community agencies whose specific role is to provide parenting education, assess parents for domestic violence, and refer them for care as needed. CDPH also allows domestic violence agencies access to WIC and CDPH clinics to assess and

provide counseling to clients.

The Chicago Safe Start Project is a demonstration project that has been funded since 2000 by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. The project's mission is to prevent and reduce the negative impact of exposure to violence on children ages five years and younger. This work is achieved through a balance of prevention and intervention efforts focusing on education, professional development, direct service innovation, and systems change oriented collaboration among city and state service providers, community organizations, and residents. The project has successfully influenced change in many systems that have contact with infants and children exposed to violence and the Safe Start evaluation indicates that their clients are improving as a result of the clinical services rendered.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Healthy Families Illinois provides voluntary home visits to at-risk families with young children | | X | | |
| 2. Parents Too Soon programs provide home visits and peer groups to first time teen parents | | X | | |
| 3. Other teen parenting programs help clients develop effective parenting skills | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

Healthy Families Illinois (HFI) works with families who are at risk of child maltreatment. Principles and practices of infant mental health are very much a part of the HFI model. Infant mental health is concerned with the promotion of social-emotional well being in babies as well as the early detection and treatment of mental health problems. A goal of the intervention is to help the primary care giver be aware of and attend to the "internal life" of the baby. For at-risk parents, immaturity, chaotic environments, a history of abuse, or other factors may present obstacles to this natural "tuning-in" process. The home visitor facilitates the bonding process and many home visitors have noticed a moment when the baby goes from being described by the parent as an "it" to being a person. This approach to service delivery is stressed through the training provided to HFI home visitors and reinforced through clinical supervision.

## c. Plan for the Coming Year

This performance measure will be addressed by the Healthy Families Illinois and Parents Too Soon programs. The MCH program will also work closely with the Illinois Department of Children and Family Services to implement the "Strengthening Families Initiative." This new initiative will be operating pilot projects in Kane County, the North Lawndale Community Area in

Chicago, southern Cook County, Peoria, and the "Southern 7" counties (Alexander, Hardin, Johnson, Massac, Pope, Pulaski and Union Counties).

Chicago. Through its Community Development Block Grant, the CDPH will continue to monitor community agencies whose specific role is to provide parenting education, assess parents for domestic violence, and refer them for care as needed. The CDPH staff will also continue to assess women for domestic violence and refer them for counseling, and continue to allow domestic violence agencies access to WIC and CDPH clinics to provide assessment and counseling to clients. This year CDPH staff will receive training to ensure that these referrals and collaborations to share information meet HIPAA guidelines for confidentiality. The Chicago Safe Start programs will continue.

State Performance Measure 5: *The proportion of CSHCN ages 14 and above and their parents who receive comprehensive transition planning services to promote awareness of adult services*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 80 | 75.0 | 68.0 | 71.0 | 74.0 |
| Annual Indicator | 65.0 | 65.3 | 70.9 | 71.6 | 76.3 |
| Numerator | 1507 | 1404 | 1541 | 1514 | 1602 |
| Denominator | 2317 | 2149 | 2172 | 2115 | 2100 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 77.0 | 77 | 77 | 77 | 77 |

a. Last Year's Accomplishments

Illinois again achieved its goal of ensuring that 74.0 percent of the youth over 14 years of age and their parents received comprehensive transition planning from or by DSCC staff. Actual performance in FY'04 was 76.3 percent. This was a 4.7 percent improvement from SFY'03. Data collection shows that 62.1 percent of youth/ families received medical transition planing, 64.6 percent received vocational transition planning, and 58.5 percent received assistance and planning for community involvement/community living. This data demonstrated improved levels of activity in each of the areas. The data does not include efforts made by other state agencies providing transition assistance.

In SFY'04 Regional Office transition technical assistance site visits were provided by DSCC transition project personnel. These site visits assisted staff by sharing effective strategies, promoting promising practices, acknowledging and encouraging transition efforts, providing updates on statewide activities and resources, and evaluating transition services implemented

over the past year. Care coordinators reported on transition successes, challenges and frustrations. Care coordinators continued to provide transition information and promote transition planning with many youth and families through phone discussions, home visits, mailings and development of individualized Transition Plans. Regional Office staff have increased their involvement with local transition planning committees and transition fairs.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Medical transition materials available on website | | | | X |
| 2. Care coordination staff development on transition | | X | | |
| 3. Evaluation of transition planning | | | | X |
| 4. Promoting awareness of transition issues/resources | | | | X |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Transition technical assistance site visits are provided twice a year to each regional office. Typical technical assistance activities may include: Case scenarios; activities that address ways to introduce transition topics; lists of developmentally appropriate DSCC materials available to assist in education and planning; lists of resource and referral information available, and ways the care coordinator can provide follow-up and elicit feedback from youth and families. These visits also provide DSCC staff with individualized assistance as needed and promote ongoing transition planning with youth and families served by DSCC.

In June 2005, DSCC supported ten families (parents and youth) to attend Illinois' first Annual Statewide Transition conference. DSCC staff from throughout the state also attended. The conference offered youth, educators, families, and community representatives opportunities for skill development, education and training in planning for positive post-school outcomes for youth in the areas of advocacy, employment, community living, education and fiscal management.

Materials for use with CYSHCN with intellectual challenges have been developed and currently are being reviewed by staff from three regional offices for feedback prior to finalizing these materials and implementing statewide. DSCC was fortunate to receive technical assistance from the Healthy and Ready to Work National Center addressing materials for individuals with intellectual disabilities along with additional technical assistance. Links to transition materials for use with this population are available on DSCC's website.

DSCC continues to assist families with identifying medical providers experienced in caring for adults with special needs and willing to provide care for YSHCN as they transition to adult health care. Outreach activities and networking are continually occurring.

A transition survey was disseminated in March 2005 to a random selection of 385 DSCC youth

and young adults between the ages of 14 and 21. A similar survey tool was sent out in SFY'03 as a baseline measurement. The survey tool will help DSCC evaluate transition services in the areas of health care transition, helpfulness of DSCC assistance and transition materials, agencies and other programs services assistance, self-care information, future planning for independent living and employment status. In addition to this survey, DSCC's Illinois Children with Special Health Care Needs Survey of families receiving DSCC assistance was modified to include questions related to transition services as part of the Five Year Needs Assessment.

### c. Plan for the Coming Year

DSCC plans to continue to promote comprehensive, collaborative transition planning statewide and specifically for DSCC youth. DSCC will continue updating a transition partner list with contact information specific to each regional office's geographic service area. DSCC will initiate an Intranet transition web board for staff use to share and inquire from other care coordinators throughout the state effective strategies, resource information and to acknowledge colleagues supporting promising practices. DSCC will continue to look for opportunities to support youth and their families in attending informational meetings and workshops on transition.

State Performance Measure 8: *The proportion of women and children up to 22 years of age who receive appropriate genetic testing, counseling, education and follow-up services*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 2.0 | 2.0 | 2.0 | 1.5 | 1.5 |
| Annual Indicator | 1.6 | 1.6 | 1.4 | 1.7 | 1.2 |
| Numerator | 92342 | 94843 | 87667 | 101954 | 75981 |
| Denominator | 5947200 | 6091399 | 6091399 | 6091399 | 6091399 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 1.5 | 1.5 | 1.5 | 1.5 | 1.5 |

**Notes - 2003**

Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2003), Genetics Program. The 2000 Census estimate provided by the Genetics Program was not reported until 2001 and will be continually used for this measure.

**Notes - 2004**

Source: Total number served by clinical genetic, pediatric hematologist, and local health department grantees (data collection provided by quarterly reports for 2004), Genetics Program. The 2000 Census estimate provided by the Genetics Program was not reported until

2001 and will be continually used for this measure.

## a. Last Year's Accomplishments

Rationale. This performance measure was chosen because Illinois has a substantial number of newborns, children and adults whose genetic conditions necessitate extensive and coordinated health care services. Although local health agencies and genetic centers do receive minimal funding, there remain communities which seriously lack any resources to meet such needs. This performance measure is placed at the direct health care level of the pyramid, and is considered a risk factor type of service. This measure will be addressed by IDPH.

Illinois did not meet its goal of increasing the proportion of women and children who receive genetic testing, counseling, education, and follow-up services. The performance target was 1.5 percent and actual performance was 1.2 percent, which was down 0.5 percentage points from the previous year. Due to a change in data collection methods, data were not collected this year regarding laboratory testing received by this population. This is reflected as a decrease in the percentage of women and children receiving services.

The Genetic Counseling and Education program staff provided technical assistance to local health departments, clinical geneticists and other specialists who received funding. Local health departments received funding for nurses to serve as case managers, facilitators, educators and referral sources for all clients in need of any service related to genetics. Clinical genetics centers received funding to provide diagnosis, counseling, treatment, and long range management to pediatric and adult patients. In collaboration with specific local health departments, satellite clinics have been staffed by medical geneticists.

Chicago. In 2004, over four thousand (4,275) prenatal clients in the clinics were screened for genetic disorders. Of these, 140 (3.3 percent) of women were referred for follow-up. Of those, 109 (78 percent) kept their appointments.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. IDPH awards grants to medical centers for diagnostic, counseling and treatment services | | X | | |
| 2. IDPH awards grants to local health departments for genetic case-finding and referral | | X | | |
| 3. IDPH awards grants to pediatric hematologists at medical centers | | X | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

This performance measure is addressed through the routine operation of IDPH's Genetic Counseling program.

IDPH is contracting with the UIC School of Public Health to conduct a statewide genetics needs assessment. This needs assessment will provide a foundation for the development of a state genetics plan, which will provide guidance to the Department regarding the future delivery of genetics services over the next ten years.

### c. Plan for the Coming Year

Local health departments, clinical geneticists and other specialists will continue to receive funding to provide assessment, counseling, education, and referrals for long-term management of families with a member diagnosed with a genetic condition. IDPH's planned activities are as follows: Clinical genetics centers will provide genetic diagnosis, counseling, treatment and management to pediatric and adult patients; satellite clinics staffed by medical geneticists and counselors will be on-site at local health agencies; local health departments will provide services related to genetics; use of the Genetic Screening Tool by local health departments will be expanded; specialized services (i.e., Illinois Teratogen Information Service, pediatric metabolic and endocrine clinics and preconception/prenatal testing and counseling) will be expanded; workshops will be held for professionals, families and the general public; and IDPH will collaborate with other programs, divisions and departments in the state to provide comprehensive services to all families in need.

Chicago. The CDPH will continue to provide genetic information and referrals as needed, and will offer folic acid to all women receiving prenatal care and family planning services. Licensed genetic counselors will continue to provide genetic counseling to clients in their homes.

## State Performance Measure 9: *The prevalence of Early Childhood Caries (ECC)*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | 32.0 | 31.0 | 33 | 32 | 32 |
| Annual Indicator | 15.8 | 34.0 | 34.0 | 33.0 | 33.0 |
| Numerator | 86304 | 180240 | 180240 | 175000 | 175000 |
| Denominator | 546231 | 530600 | 530600 | 530600 | 530600 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 33 | 32 | 32 | 32 | 32 |

**Notes - 2003**

The original data as reported in 2001 and 2002 are estimates based on a 2001 sample of children in the WIC program. The denominator is the number of children who participated in the study, extrapolated to the estimated number children aged 2, 3 and 4 from the 2000 Census.

For 2003 the percent is a result of Oral Health's Early Childhood Caries Prevalence Survey of 1,080 children aged 2 through 4 years. The survey was administered at 7 provider locations throughout Illinois.

**Notes - 2004**

For 2004 the percent is a result of Oral Health's Early Childhood Caries Prevalence Survey of 1,080 children aged 2 through 4 years. The survey was administered at 7 provider locations throughout Illinois.

## a. Last Year's Accomplishments

Rationale. This performance measure was chosen because 12 of the 19 Illinois communities completing an oral health needs assessment and comprehensive oral health plan in 1997 identified early childhood caries, or "baby bottle tooth decay," as an oral health priority. This performance measure is placed at the population-based services level of the pyramid, and is considered a risk factor type of service. This measure will be addressed by IDPH.

Illinois did not achieve its goal for reducing the prevalence of early childhood caries in 2004. The goal was 32 percent and actual performance was 33 percent.

In 2001, the Division of Oral Health (DOH) completed a statewide prevalence study of Early Childhood Caries (ECC). A total of 1,079 children aged two to four years, participating in the WIC program were screened at seven locations across the state. The study found 33 percent of the children presented with ECC. The Division of Oral Health will complete a comparable study in 2006.

The oral health program conducted numerous community-based education and outreach activities to prevent early childhood caries. Interventions were conducted with parents in non-traditional settings so that parents begin thinking about oral health before they see their child's first tooth. The program also worked with interested communities to establish community-based programs designed to reduce the prevalence of early childhood caries. This included assisting communities to redesign their program and providing technical assistance.

The IDPH ECC program developed an educational tool for WIC providers based on a survey of WIC staff needs. The educational tool consists of a flip chart and take home messages. IDPH and IDHS held focus groups of WIC clients to evaluate this tool and a similar flip chart currently being used in California. The results of these focus groups were used to develop Illinois' tool. This tool is being distributed to all WIC clinics in Illinois, accompanied by appropriate training for the WIC staff.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. IDPH works with interested communities to establish community-based prevention programs | | X | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

| | | | | |
|---|---|---|---|---|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## b. Current Activities

The IDPH, IDHS, and IDHFS, in collaboration with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), have evaluated national efforts to utilize fluoride varnishes for ECC prevention. The IDPH and IAP are creating a training program to teach pediatricians to apply fluoride varnishes, screen children, provide anticipatory guidance and refer families to dentists for oral health care.

IDPH Division of Oral Health and the DHS WIC program are implementing a statewide oral health education program for women, infants and children participating in the WIC program. The program goal is to improve the oral health status of pregnant women and very young children through oral health education. The educational program is created to increase oral health knowledge and to change behaviors aimed at increasing demand for oral health care for pregnant women and very young children and to decrease the prevalence of early childhood caries among children participating in the WIC program.

## c. Plan for the Coming Year

IDPH DOH is implementing an early childhood caries (ECC) prevention project based on recommendations found in the Illinois Oral Health Plan (Spring 2002). The project will build oral health infrastructure within MCH programs and institutionalize oral health assessment, education, preventive care and case management for Medicaid/ SCHIP-enrolled children and other under-served children and their families.

This project will assist Illinois communities to implement priorities articulated in the Illinois Oral Health Plan (IOHP). The project goal is to integrate oral health into MCH programs. The project outcome objectives are to: (1) decrease the proportion of children who have dental caries experience; (2) increase utilization of the oral health system by children and adults enrolled in Medicaid/SCHIP; and (3) increase the number of local health departments with an oral health component. Project process objectives include: a) increase to 100 percent the proportion of WIC, FCM and Head Start programs providing oral health education, risk assessment and case management; b) increase the proportion of WIC, FCM and Head Start programs providing oral health screening and preventive care; c) increase the proportion of Illinois Pediatricians and their nursing staff trained and certified to provide client oral health education, screening, preventive care and dental referral; d) revise Illinois Medicaid policies to cover appropriate oral health procedures by non-dental providers; and e) develop a system to collect oral health data through the WIC, FCM and Head Start programs. This ECC prevention project is a comprehensive integrated support system that will strengthen State strategies to integrate oral health into State MCH programs, address MCHB performance measures in oral health and stimulate action toward implementation of the Surgeon General's National Call to Action to Promote Oral Health as it affects women and children. DOH will expand an oral health education program to integrate oral health assessment, preventive care, and case management through the WIC, FCM and Head Start. This program will engage the primary care community to integrate oral health into their practices. Program institutionalization will be assured through ongoing surveillance, staff training and Medicaid reimbursement. Phase One of the project will institutionalize the oral health education component of the oral health program in WIC, FCM and Head Start, and engage pediatricians and other primary care providers to integrate oral health into their practices and to work with the ICAAP to develop a certification course. The course will cover oral screening, risk assessment, anticipatory guidance, fluoride varnish application, and referral. IDPH DOH will develop and implement a policy agenda that positively impacts state and federal Medicaid and WIC policies that will facilitate oral health

integration into MCH programs.

State Performance Measure 11: *The percent of teen parenting program participants who graduate from high school or receive their GED*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance Objective | | 52.0 | 52.5 | 59 | 40 |
| Annual Indicator | | 51.6 | 58.5 | 37.5 | 35.8 |
| Numerator | | 1048 | 1088 | 1054 | 1075 |
| Denominator | | 2031 | 1859 | 2813 | 3005 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 36 | | | | |

**Notes - 2003**

In FY03, the Teen Parent Services program focused on increasing the number of clients in education, a 52 percent increase in total unduplicated count in GED/HS from FY02. Also there was a 4 percent decrease in the total unduplicated count in the proportion of teens who completed GED/HS in FY03.

**Notes - 2004**

Source: IDHS, Cornerstone. Number of participants aged 18-20 in a GED or HS12 component program during SFY2004. The numerator includes those who received their diploma or GED.

a. Last Year's Accomplishments

Rationale. This performance measure was chosen to emphasize the importance of educational attainment in reducing dependence on public programs and attaining economic self-sufficiently which is at the core of DHS' mission. It is placed at the "enabling" level of the pyramid, addresses the population of children and adolescents and addresses risk factors for welfare dependence. Programs promoting school completion are Teen Parent Services, Parents Too Soon, Subsequent Pregnancy Prevention, Responsible Parenting, Teen Parent Services, and Healthy Families Illinois.

Illinois did not meet its goal of 40 percent in 2004; actual performance was 35.8 percent.

The Department implemented a set of performance measures for its programs for teen parents. There are three performance measures for parents and three for their children. The performance measures for parents are: completion of high school (through graduation or by obtaining a General Equivalency Diploma), delay of subsequent pregnancy and participation in parenting skills training. The performance measures for their children include: current

immunization, use of well child care, and screening for developmental delay. These performance measures are also being used by the Teen Parent Services, Parents Too Soon, Healthy Families Illinois, Responsible Parenting and Subsequent Teen Pregnancy Prevention projects. This broadens the Department's data collection from programs that were already addressing school completion and other aspects of supporting teen parents.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. The Teen Parent Services program helps young parents on TANF or KidCare complete high school or its equivalent | | X | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

Teen parenting programs will continue to help low-income teen parents finish school and make the transition from welfare dependence to work.

The Department uses a set of three performance measures for parents and three performance measures for their children. The performance measures for parents are: completion of high school (through graduation or by obtaining a General Equivalency Diploma), delay of subsequent pregnancy, and participation in parenting skills training. The performance measures for their children include: current immunizations, use of well child care, and screening for developmental delay. These performance measures are being used by the Teen Parent Services, Parents Too Soon, Healthy Families Illinois, Responsible Parenting, and Subsequent Teen Pregnancy Prevention projects. This will broaden the Department's data collection from programs that were already addressing school completion and other aspects of supporting teen parents.

c. Plan for the Coming Year

This performance measure is discontinued.

State Performance Measure 12: *The number of MCH and CSHCN program staff who participate in leadership development programs.*

| Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]* | | | | | |
|---|---|---|---|---|---|
| **Annual Objective and** | **2000** | **2001** | **2002** | **2003** | **2004** |

| Performance Data | | | | | |
|---|---|---|---|---|---|
| Annual Performance Objective | | | | | 100 |
| Annual Indicator | | | 0 | 0 | 63.6 |
| Numerator | | | | | 21 |
| Denominator | | | | | 33 |
| Is the Data Provisional or Final? | | | | Final | Final |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 0 | 60 | | | |

**Notes - 2002**

This performance measure will take effect in FFY'04. IDHS has planned for 30 participants each year.

There are no data for this year.

**Notes - 2003**

This performance measure will take effect in FFY'04. IDHS has planned for 30 participants each year.

There are no data for this year.

**Notes - 2004**

In FY2004 and FY2006, performance is measured on enrollment in the Illinois Institute for Maternal Health Leadership (IIMHL). The IIMHL estimates that 20 individuals (60.6%) will participate in the new MCH Emerging Leaders Institute in FY2006.

## a. Last Year's Accomplishments

Rationale. This performance measure was chosen to highlight the Illinois Institute for Maternal and child Health Leadership and the Illinois Maternal and Child Health Data Use Academy as efforts to develop the program knowledge and leadership skills of maternal and child health program staff at the local, regional, and state levels. The objective is directed to the "infrastructure building" level of the pyramid and is considered a "capacity building" service. IDHS will continue to work with the UIC School of Public Health's Center for Public Health Practice to conduct these programs. This effort is supported by Illinois' State Systems Development Initiative grant.

Illinois met its enrollment goal of 33 participants in FY'04.

The Illinois Institute for Maternal and Child Health Leadership (IIMCHL) provides an introduction to the core functions of public health and develops leadership skills through the completion of a team project and an individual project. The projects deepen each participant's knowledge MCH theory and practice. The team project also provides each participant with experience in teamwork, an essential aspect of public health leadership. The institute's curriculum addresses the Public Health Foundation's core competencies of Policy Development and Program Planning, Communication and Leadership, and Systems Thinking.

The IIMCHL is divided into three sessions an opening, a midpoint, and a closing session - that

are spread over the course of a year. The opening session includes presentations and case studies on each of the three core functions. The presentations are given by MCH leaders from local health departments across the state. The midpoint session includes a presentation on the history of CSHCN services given by Illinois' CSHCN Director and a half-day workshop on collaboration. The teams present their projects during the midpoint session. Participants present their individual projects during the closing session.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| Activities | Pyramid Level of Service | | | |
|---|---|---|---|---|
| | DHC | ES | PBS | IB |
| 1. Conduct the Illinois - Maternal and Child Health - Emerging Leaders Institute | | | | X |
| 2. Conduct the Illinois Maternal and Child Health - Management Academy | | | | X |
| 3. Conduct the Illinois Maternal and Child Health Leadership Society | | | | X |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The fourth DUA is underway. This time, the initial team orientation was conducted in each participating community's local health department. This change enhanced team building at the beginning of the academy. Participating teams view lectures by videotape, complete exercises and participate in teleconferences with national experts as they have for previous sections of the DUA. The same format was used for the midpoint session that has been used previously. The midpoint session scheduled for March 2005 was cancelled because too few community team members from partner agencies were able to take time out for a two-day meeting. The closing session is planned for August 2005.

c. Plan for the Coming Year

This performance measure is discontinued.

State Performance Measure 13: *The prevalence of childhood lead poisoning*

Tracking Performance Measures
*[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*

| Annual Objective and Performance Data | 2000 | 2001 | 2002 | 2003 | 2004 |
|---|---|---|---|---|---|
| Annual Performance | | | 7 | 5.7 | 4.8 |

| | | | | | |
|---|---|---|---|---|---|
| Objective | | | | | |
| Annual Indicator | | | 6.3 | 4.9 | 3.9 |
| Numerator | | | 16653 | 13140 | 9902 |
| Denominator | | | 263069 | 267997 | 254191 |
| Is the Data Provisional or Final? | | | | Final | Provisional |
| | **2005** | **2006** | **2007** | **2008** | **2009** |
| Annual Performance Objective | 4.6 | 4.2 | 3.7 | 3.6 | 3.5 |

a. Last Year's Accomplishments

Rationale. This performance measure was chosen because Illinois has a substantial number of lead poisoned children. The Healthy People 2010 objective is to eliminate the prevalence of blood lead levels exceeding 10 mcg/dL to 0 in children aged 1-5. Illinois' rate of lead poisoning is significantly higher than the national average, and of similar size states. Although local health departments receive a minimal amount of funding for testing and follow-up, there remains a need to expand program services within the local health departments and to provide reimbursements that more equally meet the costs of providing services.

Illinois exceeded its goal for reducing the prevalence of childhood lead poisoning to 4.8 percent in 2004. Actual performance was 3.9 percent.

In calendar year 2004, blood lead tests were reported on 254,191 children; 9,902 children had at least one blood lead test result greater than or equal to 10 mcg/dL, a 3.9 percent prevalence rate. The numbers of children being tested have remained consistently high over the last three years, and the rate of lead poisoning in Illinois has been steadily decreasing. In spite of this progress, Illinois rates remain among the highest in the country. The most recent national average was 2.2 percent in 1999-2002. The Illinois Childhood Lead Poisoning Prevention Program (CLPPP) also began monitoring the number of children under age 3 being tested in an effort to increase testing in this high risk population. The baseline number of children less than three years of age tested in calendar 2003 was 137,262. A total 6,232 children under age three were identified with elevated blood lead levels, a rate of 4.5 percent.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

| **Activities** | **Pyramid Level of Service** | | | |
|---|---|---|---|---|
| | **DHC** | **ES** | **PBS** | **IB** |
| 1. Increase the number of at-risk children screened for lead poisoning | **X** | | | |
| 2. Establish a statewide Lead Elimination Advisory Council | | | | **X** |
| 3. Establish local advisory committees to develop lead elimination plans | | | | **X** |
| 4. Coordinate activities with lead hazard reduction grant programs | | | | **X** |
| 5. Educate pregnant women and families with children under three years of age about lead poisoning | | **X** | | |
| 6. Train medical residents and nursing students on appropriate clinical management of lead-poisoned children | | | | **X** |
| 7. | | | | |

| | | | | |
|---|---|---|---|---|
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

b. Current Activities

The Illinois Childhood Lead Poisoning Prevention Program has established the Illinois Lead Elimination Advisory Council, and is working on implementing a statewide strategic plan for the elimination of childhood lead poisoning. In addition, communities with high prevalence rates were identified as targeted high-risk
communities, namely: Winnebago County; Peoria City/County; East Side Health District; City of Springfield; Henry County; Knox County; and Rock Island County.

These high-risk targeted communities have established their own advisory council and are working on lead elimination activities in their respective areas of jurisdiction.

c. Plan for the Coming Year

Plans for FY'05 include: targeting pregnant women and young children for lead prevention education; continuing to target high-risk communities for lead elimination activities; continuing to work with Lead Elimination Advisory Councils; and maintain the high number of children tested for lead. The prevalence rate for 2005 should be 4.6 percent.

## E. OTHER PROGRAM ACTIVITIES

Please refer to "Agency Capacity" for a complete description of Illinois' Title V program.

## F. TECHNICAL ASSISTANCE

No technical assistance is requested.

## V. BUDGET NARRATIVE

## A. EXPENDITURES

A. Expenditures
Form 3. The state's expenditures for the federal-state partnership for FY'04 are $8.2 million, or 6.5 percent, above the amount budgeted. The Department has expended all but $3.36 million of the federal allocation for FFY'04 by the end of that fiscal year. (The full allocation has been expended since that time.) The state also expended $458,300 less in state funds than the amount budgeted. The amount of local funds expended (matching funds provided for abstinence-only education) was slightly higher ($10,700) than the amount budgeted. The amount of program income (third party payments and patient fees collected by Family Planning program grantees) was $500,100 greater than the amount budgeted. The largest difference from the budget for FFY'04 was the $11.5 million increase in other state funds. The Department added $15 million in expenditures of Illinois General Revenue funds for Early Intervention services to the "state funds" used for MCH Block match. This offset the transfer of $15 million in Illinois General Revenue Funds for the Family Case Management program to "other state funds." These funds are now used as state match for Medicaid administrative expenditures through the Family Case Management program. This transfer allowed the state to obtain and addition $7.5 million in matching funds through the Medicaid program. Expenditures for some other programs included in "other state funds" were less than the amount budgeted.

DSCC expended $18.8 million for CSHCN from all sources in FFY2004, a reduction of $.8 million from FFY2003. Factors that led to the reduction in spending for CSHCN was a decrease in the aggregate MCH Block Grant funds distributed to Illinois and the State's cutback in the percent of Title V funds provided to DSCC for CSHCN from 32.1 percent to 30 percent. These reductions alone accounted for nearly all of the reduced spending for CSHCN in FFY2004. In addition to the reduction in federal dollars, there was approximately $1 million less of State funds expended for CSHCN in FFY2004 than the previous year. In order to supplant this decline in State funds, DSCC worked with the Illinois Department of Public Aid to generate new sources of funding for CSHCN through Medicaid Administrative Claiming of care coordination services.

Form 4. Expenditures for services provided to pregnant women were $1.8 million, or 8.1 percent, less than the amount budgeted. This was due to a shift in the composition (the proportion who were pregnant women, infants, children, adolescents and others) of persons served by the "MCH Mini Block Grant" to the Chicago Department of Public Health. The expected proportion of pregnant women used in budgeting (24 percent) was greater than the proportion used in allocating expenses (15 percent).

Expenditures for services provided to infants were $12.9 million, or 35.8 percent, greater than the amount budgeted. This reflects the addition of $15 million of Illinois General Revenue expenditures for the Early Intervention program described earlier.

Expenditures for children were $451,000, or 1.1 percent, less than the amount budgeted.

Expenditures for children with special health care needs were $789,000, or 4.4 percent, less than the amount budgeted. DSCC expended $18.8 million for CSHCN from all sources in FFY'04, a reduction of $0.8 million from FFY 2003. Factors that led to the reduction in spending for CSHCN was a decrease in the aggregate MCH Block Grant funds distributed to Illinois and the State's cutback in the percent of Title V funds provided to DSCC for CSHCN from 32.1 percent to 30 percent. These reductions alone accounted for nearly all of the reduced spending for CSHCN in FFY 2004. In addition to the reduction in federal dollars, there was approximately $1 million less of State funds expended for CSHCN in FFY 2004 than the previous year. In order to offset this decline in State funds, DSCC worked with the Illinois Department of Healthcare and Family Services to generate new sources of funding for CSHCN through Medicaid Administrative Claiming of care coordination services.

Expenditures for services provided to other persons was $2.0 million, or 22.9 percent, less than the

amount budgeted. This reflects a change in the allocation of Program Income. The entire amount (which comes from the Family Planning program) was budgeted for "others" but has been allocated among "children and adolescents" and "others" based on the number of adolescents served through the Family Planning program.

IDHS budgets indirect costs for staff and audit costs as "administration" for the MCH Block Grant. The Block Grant was not charged for audit expenses in FFY'04. Indirect costs are included in direct expenditures by the Department's cost allocation system, so there are no expenditures for administration.

Form 5. Expenditures for direct health care services were $1.5 million, or 6.7 percent, less than the amount budgeted. This was largely due to a reduction in expenditures by DSCC for services to CSHCN.

Expenditures for enabling services were $9.1 million, or 9.9 percent, greater than the amount budgeted. This reflects the addition of $15 million in expenditures for early intervention services to offset the use of $15 million in Family Case Management funds as matching funds for the Medicaid program.

Expenditures for population-based services were $53,400, or 1.4 percent, less than the amount budgeted.

Expenditures for infrastructure-building services were $687,600, or eight percent, greater than the amount budget. This resulted from the allocation of additional training expenditures and reallocation of IDPH's expenditures of MCH Block Grant funds from "population based" to "infrastructure building."

## B. BUDGET

IDHS, DSCC and IDPH use state General Revenue Funds, Tobacco Settlement funds, Title IV (DCFS) funds, Title X (Family Planning) funds, Title XX (Social Services Block Grant) funds, MCH Set-aside funds, Healthy Start Initiative funds, and USDA funds for Special Supplemental Nutrition Program for Women, Infants and Children (WIC), in addition to Title V Block Grant funds to achieve the objectives described in this application.

The amount of state support for the MCH program was $27,569,600 in FFY'89. The required match for FFY'06 is $17,173,900. The State of Illinois has exceeded these requirements by providing $32,433,500 in State funds.

IDPH had five "programs of projects" in 1981. Maternal and Infant (M&I) and Children and Youth (C&Y) projects were consolidated with the childhood lead project at the Chicago Department of Health and continue as a consolidated MCH project (the "MCH Mini Block Grant"). The Winnebago Family Planning Project and the Lake County Family Planning Demonstration Project continue as part of IDHS' comprehensive Family Planning program. The Intensive Infant Care Project at St. Francis Medical Center in Peoria continues to operate as a part of the Illinois regionalized perinatal care program. The amount of funding awarded to each project is as follows: Winnebago Family Planning,$420,500; St Francis Perinatal Center,$331,000; Chicago Department of Public Health (M&I, C&Y) $4,600,000; Lake County Family Planning Demonstration, $398,800 and the Dental Projects, $350,000.

IDHS has continued to direct funds to mandated Title V activities. Funds allocated to the State under this Title will only be used in a manner that is consistent with Section 508 to carry out the purpose of Title V or to continue activities previously conducted under the Consolidated Health Programs. IDPH continues to fund statewide projects addressing lead poisoning, genetic diseases and the SIDS program, while IDHS continues to fund programs related to adolescent pregnancy.

Sections 501(a)(1)(A) through (D) of the Social Security Act as amended by OBRA'89 describe the basic purposes of the MCH Block Grant. Illinois plans to use MCH Block Grant funds to achieve these purposes through its system development activities, as well as by providing grants for preventive and primary care services to agencies statewide. The purposes outlined in Sections 501(a)(1)(A) and (B) are achieved by the grants IDHS awards for family case management and adolescent health promotion and the grants that IDPH awards for perinatal care. The purpose outlined in Section 501(a)(1)(C) is achieved by DSCC, in part with MCH Block Grant funds. The purpose outlined in Section 501(a)(1)(D) is the principle responsibility of DSCC. The proportion of funds used for Sections 501(a)(1)(A) and (B) is 70 percent, and for Sections 501(a)(1)(C) and (D) is 30 percent.

IDHS receives the MCH Block Grant and administers primary care programs. IDHS transfers 30 percent of its block grant funds to DSCC for the CSHCN program. IDHS gives highest priority to those areas in Illinois that have high concentrations of low-income families (an area where 20 percent of the families, or at least 1,000 individuals, have an income at or below the federal poverty level), that are medically under-served areas, or are areas of high infant mortality and teenage pregnancy. Priority is also given to areas of high poverty rates which have a demonstrated need for services. Program grants are awarded to local political jurisdictions or private, non-profit agencies. Applications are reviewed by a committee and recommendations for funding are made to the Secretary of the Illinois Department of Human Services. Continuation applications receive priority in order to maintain continuity of services.

IDHS has not established a fee scale for use by its MCH program grantees and has no plans to do so. Each project funded through the MCH program may elect to charge eligible recipients for certain services provided by the project. However, a flexible sliding fee scale must be used when a project intends to charge for services and no fees are charged to low-income clients. The fee scale must be included for approval in the project application prior to any fees being charged. Further, all projects are required to have agreements with the Medicaid program for reimbursement of covered services for project patients who are Title XIX or Title XXI recipients. Steps must also be taken to obtain reimbursement from non-profit, semi-private and private medical insurance programs when those programs cover services rendered by the projects. Finally, outpatient services must be provided at rates established by the Illinois Department of Healthcare and Family Services for the Medicaid program. These provisions are made to ensure that mothers and children from low-income families are not charged for services.

Through effective benefit management strategies, DSCC was able to offset project budget deficits, as they would potentially impact available funds for direct services. These strategies include increased staff training on benefit plans, contract discounts with the insurance carrier, utilization of negotiated provider or carrier write-offs, and the use of dispute resolution techniques. In FFY 2004, DSCC was able to realign funds to assist families through enabling services in accessing health care by providing financial assistance for transportation and establishing a family incentive program to maximize health benefits by reimbursing families for insurance co-payments on medical visits and medications.

## VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

## VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## IX. Technical Note

Please refer to Section IX of the Guidance.

## X. Appendices and State Supporting Documents

### A. Needs Assessment

Please refer to Section II attachments, if provided.

### B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

### C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

### D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.